PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

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Can You Help?

THE Army needs 10,000 more nurses—and desperately. Only half the recent nursing graduates that were expected to enter the Armed Services have done so. Recruitment of older nurses has slowed up along with the belief that the war in Europe is over. The combined operations campaign for 4,000 nurses in September brought only a few hundred additional enrollments.

No one who heard Congressman Frances Payne Bolton's moving talk in New York City on October 20 before the National, City and Long Island Nursing Councils for War Service, on her return from a two-month inspection tour of American Army hospitals in England and France, could possibly question the grim necessity for meeting the call for nurses. It is addressed to every eligible nurse. What can you do?

The call is addressed equally to every agency employing nurses. Think carefully if you have held to their jobs any nurses who are able to go and desire to go into military service. Think carefully if you have resisted the entrance of senior cadets into the Army and Navy Nurse Corps. The men wounded in battle must have adequate nursing care. What can *you* do to see that their needs are met amply and promptly?

The Local Nursing Council in Peacetime

THE NURSING profession as a whole and through its several branches is beginning to adapt and modify its wartime machinery for peacetime purposes.

That the importance of sound local organization for joint planning was recognized before the war is evident from the fact that local nursing councils had already been formed in some communities. But it took the war, in accentuating the need, to hasten and expand their development. There are now 934 local nursing councils for war service in communities throughout the country.

A chief strength of these local organizations is representation from other groups in the community besides nurses. In looking forward to the well nursed community of the future, planning by the producers of nursing service is not enough. The consumer public which has learned so much more about nursing during the war obviously will have more to say about how it can best be made available, in the amounts and kinds likely to be required.

The extent to which changes will be needed in the composition and functions of nursing councils for war service in order to equip them best for peacetime work will vary from community to community. But common to all will be the need for citizen participation and guidance. This is equally true of state and national coordinating organizations, whatever their origin and title.

Decision is pending as to what form our national nursing coordinating machinery will take after the wartime needs for which the NNCWS was created are over. In the meanwhile, there are certain community nursing jobs to be performed jointly.

(Continued on page 574)

Community Planning for Peacetime Nursing Service

By ALMA C. HAUPT, R.N.

THE TIME HAS COME to plan for the reconversion of nursing service from war to peace. To this end, the national nursing organizations have revised the "Tentative Outline for a Survey of Community Nursing Service"* and brought it up to date with developments of the past five years.

Walter Lippmann has said, "The civilians who shape the peace must first keep and then develop the gains which have been achieved by the stupendous sacrifice and effort of the war." To keep and develop the gains made by nursing is the obligation of our profession and the means by which we can make our appropriate contribution to the peace. It is recognized that certain gains made in pre-war years were sacrificed during war. We need now to determine which of the gains sacrificed should be restored as well as to move forward to reach new goals.

The purpose of this discussion is to show how community planning for nursing service can help in keeping and developing the gains nursing has made, and that a community nursing survey is an essential tool in achieving this end.

Our objectives for the war have been twofold. The first and foremost was and still is, of course, to meet the nursing needs of the military. We can say with just pride that we have never let our boys and girls in the armed services down. This is due to the combined efforts of the profession, the American Red Cross, and the war nursing programs of government agencies.

Our second objective has been to meet the civilian needs on the home front. Here we have been only partially successful. At first, we had considerable dislocation when rapid demands were made by the military. It is only as the program of Procurement and Assignment Service for Nurses has gotten under way that classification has helped to distribute the right nurse to the right job. This has been greatly facilitated by the increased nurse power provided through the U. S. Cadet Nurse Corps, by the return of inactive nurses to work, by the increased use of auxiliary nursing personnel both paid and volunteer, and by the greatly expanded teaching of home nursing through the American Red Cross.

Nursing service for possible civilian emergencies was also adequately planned and executed by the Office of Civilian Defense and the American Red Cross. How fortunate we are that these services were not needed to any appreciable extent and how grateful we should be that their preparedness was so complete!

Our present purpose is to convert our civilian war nursing program to peacetime needs. This is our big job for the future.

WHAT, then, are the main war gains that we are justified in keeping and developing? It may be oversimplification to say that these can be sum-

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marized under four headings. The first is the spiritual gain which was made when nursing responded with unity of purpose to meet war nursing needs whether military or civilian. The fact that nursing was recognized by the public as "essential" brought new courage, new faith, and renewed energy to the whole profession.

This desire to meet the challenge led to the second and tremendous gain of closer working relationships. Great progress has been made in knowing each other regardless of whether our fields are institutional or public health nursing, nursing education, private duty, or industrial nursing. Never before has the nursing profession been so closely associated with government on federal, state, and local levels. Never before have the medical, hospital, allied professional groups, and the lay public been so widely informed about nursing and taken such an active part in it. Never before have public and private agencies been so tightly welded together for a common nursing purpose.

This is best illustrated by the formation of the National Nursing Council for War Service with branches in every state and in 934 communities. You will remember that due to the foresighted leadership of nurses who had been active in World War I, the Council was organized as far back as July 1940 as the Nursing Council for National Defense. It changed its name after Pearl Harbor. Here indeed is tremendous progress—a network of state and local councils all over the country bringing together representatives of the various branches of nursing, related professional groups, such as medicine and hospital administration, and the lay public. Here indeed is a structure such as we never had before on which to build for the peacetime future.

Our third gain is in the greater numbers of nurses and the maintenance of minimum standards of service despite painful shortcuts forced upon us by the war. In the process, we hope we have preserved the essentials of good nursing care of the patient. We have increased the enrollment of new students in schools of nursing from 38,000 in 1940 to over 65,000 in 1943. There will, of course, be a cut-back in the number of students needed as the military requirements lessen, but we now have the opportunity and the obligation of expanding nursing service to absorb all of those who, through their patriotism and faith in the future, joined our ranks. This should make it possible for us to improve the quality of service and distribute it more equitably for civilian needs.

Tremendous strides have been made by our national professional organizations, by the Procurement and Assignment Service for Nurses, by the U. S. Cadet Nurse Corps, and the nursing services of the Federal Government in developing both qualitative and quantitative measurements. Although some of them are designed for minimum wartime essentials, they form a solid basis for planning possible peacetime criteria.

Cooperative planning is the fourth gain of our wartime program. The major function of the National Nursing Council for War Service and the Subcommittee on Nursing of the Office of Defense Health and Welfare Services was to plan and, on the basis of sound planning, to take action. How many nurses were needed? What kind of nurses were required? Where were they most needed? How could they be obtained and distributed? Such national planning lifted the eyes of the nursing profession away from relatively insignificant detail to a broad gauge view of the total situation. As state and local nursing councils went into action, this same process was at work, its success varying according to the activity and leadership of those concerned with programs in the various states and localities.

OUR WAR GAINS challenge us to make our appropriate contribution to peace. Certainly we want to maintain a spirited unity of purpose to provide a higher quality of nursing service in the proper amount to all civilians who need it no matter where they live; no matter what their race, creed or color; no matter on what economic level they live. At the same time, we want to assure all the nurses in military service proper employment on their return home, and we must maintain adequate jobs for the nurses on the home front and the students who answered the call of their country.

It is none too soon, then, for our nursing councils throughout the country to begin making new surveys of all nursing services available in each community and of current and future nursing needs. It is likewise none too soon for those councils which previously made surveys to bring them up to date.

The revised outline for a survey of community nursing service is merely a guide to local groups in appraising resources and needs. It may be used by an "expert" who is engaged to come in from the outside to review the local nursing situation. It may be used by members of the local nursing council who divide up the job among individuals or subcommittees, each for a special section of the survey. In communities where no council exists, it may be used by a special survey committee organized for this one purpose. Such a committee may function as a separate entity or as a part of the council of social agencies or the health council. No matter under what local arrangement it is made, the survey outline is best used by a local group representative of the major branches of nursing, allied professional groups, and interested laymen. If an outside expert is brought in, a council or committee is needed to assist in fact-gathering, analysis of findings, and planning for future changes. Because the making of a survey is a complicated procedure, leadership in social planning and the help of a committee with an objective viewpoint are all important.

THE OUTLINE begins with a section called "Community Picture," in in which entry spaces are provided for population figures, income and expenditures from both public and private sources for all types of nursing, mortality and morbidity figures, and the listing of all the nursing resources of the community, clinic services, and hospital beds. The succeeding sections consist of detailed questionnaires relating to each one of the following subjects:

Registry service
Hospital nursing service and associated school of nursing
Public health nursing service in the health department
Public health nursing as part of the school health service
Public health nursing in voluntary or private agencies
Industrial nursing
Office nursing

The questionnaire for each type of service covers history, organization, administration, finances, program, conduct of public information program, community relationships, and ends with, "List of the unmet needs for nursing service."

From such data it is proposed that each community make up a summary chart showing the total number of workers engaged in each type of nursing service in the community and the agencies through which their services may be secured.

Naturally, a study outline cannot arrive at conclusions or make recommendations as to what needs to be done. That must be left to the committee which gathers the facts and weighs them in relation to suitable standards of quality and quantity. However, the very process of forming a committee for a common purpose is sure to bring a new and closer alignment of all nursing groups

with one another and with related professions and the public. The fact-gathering process itself will likewise be educational and tend to bring about better understanding and finer cooperation of those concerned. No group should be discouraged because it cannot get all the facts—the facts available will at least be a starting point for discussion. Absence of facts is sometimes more tellng than a row of numerals.

If carried to its logical conclusion, a survey should, of course, lead to joint thinking on the part of the study group as to wastage, duplication, omissions, improvement of standards, and increase of volume of service where indicated. A survey is merely a basis for action. Action of the right sort involves a representative group with high ideals, good judgment, courage, patience, and real community leadership.

The question was recently asked over the radio, "What is better than our past?" In nursing, we would be stultified indeed if we were to rest on any past achievements. We know that we have much still to achieve in providing better care to civilians and better distribution of nursing service. The very fact that the United States Public Health Service reports 13 cities and almost 850 counties as having no public health nursing service of any kind gives a hint of our problem. There are basic economic questions still to be solved in terms of salaries, hours, and working conditions for nurses. The whole field of the inclusion of nursing benefits in prepayment health schemes is just opening up. And we see a growing demand for nursing service as there are expansions in the health and hospital programs of the Federal Government. The Veterans Administration will need increased numbers of nurses and nursing service of every type will have some part to play in the programs of rehabilitation.

Yes, it is none too soon to take new stock of our nursing facilities, our omissions, overlapping or duplications of service, and our needs for strengthening old organizations or forming new organizations to meet new needs. It is practical and timely for each community to use the revised outline for a Survey of Community Nursing Service to the best of its ability and to call on the national nursing organizations as necessary to assist with outside help and opinion. It took us considerable time to get our war nursing programs into operation. Let's profit by that experience and get ready now for the peacetime future we know is coming.

Think of the amount of money, organization, and personnel that was needed to plan and execute the programs for war nursing! What money, organization, and personnel do we need to keep up the momentum gained and convert to peace? This is the basic question which the proper use of a community survey should answer. If a survey has been well made, it will be a dynamic force for needed action.

We shall never reach an ideal or complete nursing situation, but we should make every effort to get as near as possible to the goal of necessary nursing service to all who need it, and the job most appropriate for every available nurse.

In the words of Robert Browning, "Oh, but that a man's reach should exceed his grasp, or what's a Heaven for!"

Nursing Study in a Home Delivery Area

By HENRY R. O'BRIEN, M.D.

A PROGRAM for mothers, infants, and preschool children was set up in Cattaraugus County in 1937 with the aid of the Children's Bureau, the New York State Department of Health, and the Milbank Memorial Fund. A part of the program was a study of the factors in maternal care which might have a bearing on maternal and infant mortality. A questionnaire, a "blue slip," was set up for physicians and inter-leaved with the regular birth certificates. At the same time an experienced clerk was sent to the nine district health stations to secure related information from the nursing records on the same cases. The Olean Red Cross Society and the Gowanda Red Cross cooperated and opened their nursing records to this study. The medical findings were presented before the Medical Society of the State of New York.[1] A partial summary of the nursing items, written from the standpoint of the public health administrator, is submitted here.

The deliveries occurred within Cattaraugus County and began with July 1, 1937. Since the nursing items included care for a year after delivery, the study closed in the summer of 1940 for the babies delivered up to July 1, 1939. Some 2,348 births were recorded in the 2-year period. A physician signed the birth certificates in all but 0.3 percent of the cases; midwives do not figure in this county. The nurse therefore appears as assisting the physician.

Cattaraugus County covers 1,343 square miles in the hills of southwestern New York. The population in 1938 was estimated at 72,607. At the time of this study public health nurses in the county were distributed as shown in Table 1.

Outside of Olean the County Department of Health (organized in 1921) was offering generalized service in the ratio of 1 nurse to 4,500 people, 11 nurses operating from 8 district stations. In Olean most of the bedside nursing was by agreement carried on by the Red Cross. Until late in 1938 a diminishing number of WPA nurses assisted the Department or Red Cross staff.

Assistance to the physician at delivery varies with the financial means of the patient. On the blue slip the doctor was asked to indicate the approximate economic status of the patient, using four groups: good, fair, marginal, or welfare.

TABLE 1. PUBLIC HEALTH NURSES IN CATTARAUGUS COUNTY

Agency	Total Nurses	Number of nurses in each type of nursing service			
		General	Bedside	School	Supervision
Total	21	12.5	2.5	4.0	2
County Department of Health	15	12.5	—	0.5	2
Olean Red Cross	2	—	2.0	—	—
Gowanda Red Cross	1	—	0.5	0.5	—
Olean Board of Education	2	—	—	2.0	—
Salamanca Board of Education	1	—	—	1.0	—

TABLE 2. DISTRIBUTION OF MOTHERS DELIVERED IN HOSPITALS

Residence of mother	Percent in each economic status			
	Good	Fair	Marginal	Welfare
All residents	83	61	37	47
Rural residents	68	47	24	32
Urban residents	94	75	61	65

In the office we also listed those applying or accepted for medical care by a welfare department. The opinion of the physician and of the welfare worker was usually the same. Some "marginal" cases applied for welfare aid, and some were accepted; others were not. At least two "fair" families made welfare application, and one apparently established its case and was accepted.

Tables 2, 3A, and 3B show what nursing service was used by each of the four groups when the baby was born.

Hospitalization and the use of hospital nurses fell with the means of the family. It rose slightly in the welfare group because, at times, doctor, nurse, and welfare worker agreed that home conditions were too poor to permit a safe delivery, and the community then underwrote the expense. In each class the rates were lower among rural residents, higher among urban. The

TABLE 3A. RELATION OF ECONOMIC STATUS AND NURSING HELP AT DELIVERY

Nursing help at delivery	Total deliveries		Deliveries in each economic status							
			Good		Fair		Marginal		Welfare	
	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent
Total deliveries	2,179	100.0	704	100.0	822	100.0	397	100.0	256	100.0
Hospital nurse	1,354	62.1	588	83.5	500	60.8	146	36.8	120	46.9
Public health nurse	271	12.4	20	2.8	94	11.4	87	21.9	70	27.3
Red Cross nurse	81	3.7	14	2.0	33	4.0	24	6.0	10	3.9
Private registered nurse	56	2.6	27	3.8	23	2.8	5	1.3	1	0.4
Practical nurse	120	5.5	26	3.7	61	7.4	27	6.8	6	2.3
Relative	176	8.1	24	3.4	69	8.4	54	13.6	29	11.3
Friend	97	4.5	4	0.6	34	4.1	41	10.3	18	7.0
No one	24	1.1	1	0.1	8	1.0	13	3.3	2	0.8

TABLE 3B. RELATION OF ECONOMIC STATUS AND NURSING HELP AT DELIVERY

Nursing help at delivery	Total		Deliveries in each economic status							
			Good		Fair		Marginal		Welfare	
	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent
Total	2,179	100	704	32.3	822	37.7	397	18.2	256	11.7
Hospital nurse	1,354	100	588	43.4	500	36.9	146	10.8	120	8.9
Public health nurse	271	100	20	7.4	94	34.7	87	32.1	70	25.8
Red Cross nurse	81	100	14	17.3	33	40.7	24	29.6	10	12.3
Private registered nurse	56	100	27	48.2	23	41.1	5	8.9	1	1.8
Practical nurse	120	100	26	21.7	61	50.8	27	22.5	6	5.0
Relative	176	100	24	13.6	69	39.2	54	30.7	29	16.5
Friend	97	100	4	4.1	34	35.1	41	42.3	18	18.5
No one	24	100	1	4.2	8	33.3	13	54.2	2	8.3

TABLE 4. HOME DELIVERY SERVICE BY A PUBLIC HEALTH NURSE*

Nurse giving service		Number of deliveries		
Delivery	Prenatal	Total	Olean	County except Olean
Total		368	77	291
Red Cross	Same Red Cross	29	17	12
Red Cross	Other Red Cross	10	10	—
Red Cross	None	9	7	2
WPA	Same WPA	23	1	22
WPA	HD or RC	16	2	14
WPA	None	7	1	6
Same nurse, of whatever agency		207	37	170
HD	Other HD	32	1	31
HD	None	33	1	32
Details not given		2	—	2

*No maternal deaths in this series.

rural borderline mother received pitifully little hospital service.

Outside the hospital, "good" families turned to no special type of nursing service. "Fair" families made some use of public health nurses, relatives and practical nurses. Both the "marginal" and the "welfare" mother called rather on the public health or Red Cross nurse, a relative, or a friend.

In all, 80.9 percent of this group had the services of a graduate nurse. This varied from 92.2 percent in "good" families to 79.1 percent in "fair" and 78.5 percent in "welfare" to 66.0 percent in "marginal." Apparently in this last group the public health nurse has an opportunity and an obligation to extend her services.

Table 3B studies the same figures horizontally. Here it is apparent that the hospitals of the county received four fifths of their maternity patients from the two upper economic groups. This is of importance in their planning. Public health nurses, on the contrary, find their work among the three lower groups. The Red Cross distribution is much the same, with some shift toward the upper economic levels. The registered private duty nurse has nine tenths of her patients in the two upper groups. With the practical nurse, as would be expected, the trend is definitely downward. Relatives and friends served also the two intermediate groups, who were also most liable to have no one helping the physician at this time.

TIME OF FIRST VISIT

A sample of 675 Health Department cases shows that in 6.8 percent the nurse called and saw the expectant mother in the first trimester; in 28.1 percent in the second trimester; and in the remaining 65.0 percent in the third. Red Cross figures for 86 cases were 3.4 percent, 15.1 percent, and 80.4 percent. This may be compared with 26 percent, 57 percent, and 17 percent in Pike County, Mississippi,[1] or with 40.5 percent, 32.2 percent, and 22.3 percent in visits of 2,126 patients to physicians.[2] These figures present a challenge to our public health nurses. At the same time, in 22 percent of a group of 489 women the public health nurse made her first visit before the patient had registered with a physician.

HOME DELIVERY NURSING SERVICE

Private city agencies have long offered home delivery nursing service, but only comparatively recently has this been extended to the rural field. So far as is

known, the Cattaraugus County Department of Health was the first rural agency in the United States to offer (1923) such service. In Olean this was largely left to the older Red Cross nursing service (discontinued in 1943), but elsewhere in the county, home delivery service is offered by the nurse as part of her thoroughly generalized program. From 1934 to 1938 both Red Cross and Department of Health nurses were assisted by registered nurses provided by the WPA. The scope and circumstances of the home delivery service are outlined in the following tables.

In 86.1 percent of these home deliveries a nurse had given prenatal care to the patient and had helped her plan for her own care, the delivery and the care of the baby. In 13.3 percent the nurse was called only for the delivery itself. All agencies try to avoid this, but it is hard to decline a last-minute call. (Table 4).

The Health Department, through its district system, made an effort to have the same nurse render prenatal, delivery, and postpartum service. This personal contact is believed to have a definite value. In fact, most of the districts did not have two nurses who could rotate on call for each other. In 56.3 percent of all these home deliveries the mother was served by the same nurse with whom she had become familiar through prenatal visits.

In these home delivery services, the nurse did not get a cross section of the births in her community. This was to be expected. The distribution in urban and rural births and in the home delivery services is shown in Table 5, according to the number of babies the mothers had.

The great majority of first deliveries occurred in hospitals; this was felt to be less necessary for the second baby. In the cities first babies were 35 percent of all the babies born, but only 10 percent of those served by the public health nurse were first babies. The difference was less marked in the country. A change began with the second baby, and mothers of third babies and higher were more likely to be the field of the city nurse. The rural nurse was less restricted, though her work showed the same trends.

TIME OCCUPIED IN DELIVERY SERVICE

How much of the nurse's time did delivery service take? This is an important point when an agency is planning its whole program. The answer is written in part in travel time, in part in time spent in the patient's home. Both the County Department of Health and the Olean Red Cross offered delivery service and not labor service. Theoretically the nurse went when the doctor did and left with him; in practice she seems to have been there a somewhat longer time, as Table 6 indicates.

TABLE 5. DISTRIBUTION OF BIRTHS BY NUMBER OF BABIES MOTHER HAD*

	Urban		Rural	
	Total births	Delivery service	Total births	Delivery service
	Percent of total			
Total	100	100	100	100
First baby	35	10	27	14
Second	27	14	25	21
Third or fourth	23	40	25	32
Fifth or more	15	36	23	33
Number included	1,348	107	1,014	239

*Based on residence of the mother.

TABLE 6. TIME SPENT BY NURSE IN PATIENT'S HOME FOR DELIVERY SERVICE

Hours	Deliveries	Percent
Total	331	100.0
Less than 1h	2	0.6
1h—1h 59m	52	15.7
2h—2h 59m	91	27.5
3h—3h 59m	78	23.6
4h—4h 59m	55	16.6
5h—5h 59m	18	5.4
6h—6h 59m	12	3.6
7h—7h 59m	7	2.1
8h—8h 59m	7	2.1
9h—9h 59m	9	2.7

The average time spent in the patient's home on a delivery was 3.6 hours, somewhat higher (3.8 hours) in rural areas, lower (3.0 hours) in urban. Only 16.0 percent took 5 hours or more. In the Fulton-Montgomery County study,[4] the average was 4.3 hours.

Babies habitually are born in out-of-working hours. In recording the amount of off-duty time involved in these deliveries, 9 a.m. to 5 p.m. was counted as on-duty time every day except Saturday and Sunday. Saturday 9 a.m. to 12 noon was on-duty. Travel time was not counted in this study. The average off-duty time spent was 2.8 hours (3.0 in rural areas, 2.3 in urban). The frequency distribution is shown in Table 7.

TABLE 7. TIME OUT-OF-HOURS SPENT BY NURSE IN PATIENT'S HOME FOR DELIVERY SERVICE

Hours	Deliveries	Percent
Total	332	100.0
None	40	12.0
Less than 1h	17	5.1
1h—1h 59m	55	16.6
2h—2h 59m	76	22.9
3h—3h 59m	70	21.1
4h—4h 59m	36	10.8
5h—5h 59m	18	5.4
6h—6h 59m	9	2.7
7h—7h 59m	2	0.6
8h—8h 59m	6	1.8
9h or more	3	0.9

How much time was taken off by the nurse in compensation is not recorded. The Department of Health had a long-standing policy whereby the nurse called out at night or on Sunday could take time off to regain her rest if she could do so within 24 hours. During this study the period was extended to 48 hours after the night work. The nurse was considered a professional person and not a clock puncher. The question seemed, therefore, one of rest and not of hours worked. The author suspects that in the demands of generalized service in her district, the nurse frequently did not take time out to compensate.

The fact that so much of the time spent in the patient's home was out-of-hours helps explain, too, how the nurse was able to carry delivery service along with other features of her generalized work, *e.g.*, school, other bedside, clinics for tuberculosis, child welfare, and other activities. Her fixed appointments were not many; few deliveries came during regular hours; only an occasional nurse had more than 15 deliveries a year. Conflicts were therefore few.

In considering the time the nurse spent in delivery service, it is well to note the time the patient spent in labor. Table 8 compares the distribution in the home delivery patients with those in the whole study.

TABLE 8. HOURS OF LABOR

Hours	Home Deliveries	All urban patients	All patients
	Percent of total		
Total	100.0	100.0	100.0
Less than 4	16.6	10.6	12.4
4-7	42.4	29.9	33.4
8-11	19.0	25.7	22.1
12-15	11.7	18.5	16.8
16-19	2.4	6.1	6.2
20-23	1.7	2.8	2.7
24-27	2.8	2.7	2.5
28 or more	3.4	3.7	3.9
Number of patients reported	290	1,075	2,105

This reflects in general the larger proportion of multiparæ delivered at home. Of the total mothers for whom data were available, 45.8 percent were in labor less

than 8 hours. Among those delivered at home, 59.0 percent were in labor less than 8 hours.

DISTANCE TRAVELED

It is of interest to note the distance which the nurse had to travel from her station to the home of the delivery. This would be reflected in "travel time" and in turn would influence the frequency of postpartum visits. In the 365 home deliveries on which information is available, for 41.6 percent, she went less than two miles. This included not only the cities of Olean and Salamanca, but also the various villages, in most of which a district station was located. That a larger percentage of the population than this lives within two miles of a district station suggests that the district nurse particularly served the outlying areas. Beyond the two miles limit, 16.4 percent were from 2 to 4 miles distant; 10.1 percent from 4 to 6; 11.5 percent from 6 to 8; 7.4 percent from 8 to 10; 6.6 percent from 10 to 12; and 6.3 percent were 12 miles or more. Although distances in Cattaraugus County are not so great as in the West, they are considerable, and make demands on a nurse's planning.

Study of nursing records reveals various incidents that arise in administration of home delivery service. In 303 instances her presence was planned for and she was there on time. Thirteen patients for whom home delivery was planned, with nursing assistance, were taken to a hospital at the last minute, because of complications. For 18 patients the presence of the nurse was planned, but for some reason (unstated) she was not there. In 12 other cases she was simply not called. On the other hand, she was called to 51 deliveries for which previous arrangements had not been made. Fifteen times she was called, but events proceeded so rapidly that the baby had already come before she arrived. On occasion the nurse delivered the baby herself, in the absence of the doctor.

It is difficult, in an area where more than half the births occur in hospitals, to prove that delivery service for the less complicated remainder lessens maternal mortality. That no maternal deaths occurred when a public health nurse assisted a physician in the home may be negative evidence only.

Nor did this study show statistically that this service saves infant lives. Yet the fact that the infant mortality in the lower economic groups was not higher than the average presents an indirect proof, as does the popularity of this service among mothers and physicians.

POSTPARTUM SERVICE

Postpartum calls were made at some time on 1,475 or 62.8 percent of 2,348 resident patients. For 27.6 percent the first postpartum visit was made on the first day, and for 44.3 percent, within the first week; for 15.3 percent the second week; 11.9 percent the third week; 8.6 percent the fourth week; and 20.7 percent the fifth week or later. The Red Cross had a larger proportion of first day calls.

Within the first two months after delivery, the Red Cross nurses averaged 6.2 visits for 268 patients. However, 63 patients received from 10 to 17 visits each. Bedside care was given in 96.8 percent of the Red Cross nursing visits, so that the load of these few cases was quite heavy.

The Health Department nurses averaged 2.4 visits within two months for 1,229 patients. In Olean their visits were fewer, 1.4 for 321 patients; while outside the city they visited 908 patients an average of 2.8 times. Only 10 patients received 10 visits or more, the largest number being 13. Counting both agencies, and including some patients who were served by both, 1,397 patients had 3.3 nursing visits each within two months postpartum. In the St. Lawrence County demonstration of special service, postpartum visits within an unstated time averaged 6.7 per patient.[4]

Of the postpartum visits by Department of Health nurses, only 22 percent

included bedside care of the patient. Of the patients visited postpartum, 20.4 percent received bedside care.

To 368 home delivery cases public health nurses paid an average of 5.3 visits postpartum, 4.2 in rural areas, and 7.8 in urban. In each area these patients evidently received additional service.

The total number of nursing visits to home delivery patients appears in Table 9.

TABLE 9. NURSING VISITS TO PATIENTS RECEIVING HOME DELIVERY SERVICE

	Total	Rural	Urban
Number of patients	368	254	114
Visits (average)			
Prenatal	3.6	3.4	4.0
Delivery	1.0	1.0	1.0
Postpartum	5.3	4.2	7.8
Total	9.9	8.6	12.8

In this field of total service during pregnancy, 1,450 or 61.8 percent of 2,348 mothers in the county received public health nursing service in some form. This is a significant rise from the 31 percent noted by Marian Randall in 1930.[3] A total of 7,576 visits were paid, an average of 3.2 for the whole group or 5.2 for the 1,450 who received some service. The median person among the 2,348 received 1.0 visit; among those who were visited the median person had 3.5 visits. Three women received 24 visits each. Almost half the total visits were paid to the 368 home delivery patients.

SOURCE OF REFERRALS

We believe that the expectant mother profits by visits from a public health nurse, who assists the physician in charge in instructing the patient in the hygiene of pregnancy. How then does the nurse get in touch with the patient whom she can help? Table 10 groups the answers. The two series are not added because some 209 patients were visited by both agencies.

Several comments suggest themselves: The practicing physicians were not making adequate use of the nursing aid that was available. Welfare workers were either not referring cases to the nurses or were not themselves learning of expectant mothers early in pregnancy. The large percentages after "birth certificate" indicate a need for stressing earlier case-finding technique.

Omitting information from birth cer-

TABLE 10. SOURCE OF REFERRAL OF NURSE TO PATIENT

	Health Department			Red Cross		
	Total	Olean	Outside Olean	Total	Olean	Outside Olean
	Number of patients					
Total	2,260	765	1,495			
Receiving no service	371	145	226			
Number receiving service	1,889	620	1,269	296	220	76
No information, but visited	324	70	254	42	5	37
Net	1,565	550	1,015	254	215	39
Source	Percent of net					
Found on visit for other services	4.9	2.2	6.3	1.6	0.5	7.7
Physician	16.3	2.6	23.7	28.3	29.3	23.1
Patient herself	10.0	4.7	12.9	33.9	36.7	17.9
Other agency or person	4.5	2.0	5.8	5.1	5.6	2.6
Welfare worker	1.5	1.8	1.3	—	—	—
Other HD service	4.5	7.3	3.0	16.5	16.7	15.4
Birth certificate	58.4	79.5	47.0	4.3	—	28.2
M.L.I.				10.2	11.2	5.1

tificates, it is noted that Department nurses outside Olean received their first information from physicians in 23.7 percent of the cases. In 1930 Miss Randall[3] found 40 percent in a study of rural practice in the county.

During the first year of the baby's existence the nurses make visits for infant supervision. Here records of 2,167 patients were studied. Visits were made to 1,638 or 75.2 percent. Of these 1,439 were home when visited, but 199 were away one or more times, resulting in 290 fruitless visits, a net loss in nursing time of considerable amount.

These nursing records contain considerable material for further study, but these findings are presented now, for comparison with similar work elsewhere.

Author's Note: Special appreciation should be expressed for the assistance of Miss Dorothy Wiehl of the Milbank Memorial Fund, who aided in preparing this nursing study and supervised much of its tabulation, to Miss Helene Buker and Miss Marion I. Murphy, director and supervisor of public health nursing, and to Miss Frances McNamara and Miss Kathleen Cramer, for their industrious and intelligent clerical service. Some of the tabulation was done in Hartford, Connecticut, where the author was Chief of the Division of Local Health Administration in the State Department of Health.

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NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Marion L. Jacobs, B.S., executive director, Yonkers Visiting Nurse Association, Yonkers, N.Y.

*A. Winifred Golley, supervising nurse, Kauai Island, Board of Health, Territory of Hawaii.

*Marcetta Horne, supervisor, public health nursing, Saginaw County Health Dept., Saginaw, Mich.

*Marie C. Sohaski, B.S., nursing field consultant, American Red Cross—Midwestern Area, St. Louis, Mo.

*Isabel R. Waterhouse, B.A., M.S., head nurse, College Health Center, Allegheny College, Meadville, Pa.

Irma L. Brunelle, B.A., director of student health, The Grace Hospital, Detroit, Mich.

*Florence Edner, staff nurse, Visiting Nurse Association, Inc., Los Angeles, Calif.

Helen Madden, public health nurse clinic manager, Montgomery Ward Clinics, Chicago, Ill.

*Mae Lammers, public health nurse, Abilene Public Schools and American Red Cross, Abilene, Kans.

*Mrs. Anna M. Kuhlmann, industrial nurse, Mechanical Handling System, Inc., Chicago, Ill.

*Ethel V. Swanson, camp nurse, Camp Nissokone, Detroit, Mich.

ASSISTED PLACEMENTS

Frances Raley, B.S., educational supervisor, Richmond City Health Department, Richmond, Va.

*Elsie B. Kocher, B.S., tuberculosis supervising nurse, Monmouth County Organization for Social Service, Red Bank, N.J.

*Tressa Walters, assistant supervisor, public health nursing, City-County Health Unit El Paso County, Colorado Springs, Colo.

Mary D. Ford, staff nurse, Agricultural Workers Health and Medical Association, San Francisco, Calif.

*NOPHN files show this nurse is a member.

My District

By VERA FRY, R.N.

FORTIFIED WITH the "Staff Nurse's Manual," the doctor's orders, and a determination to carry out all the principles I had learned, I drove rapidly toward my district, Great Bay Circle. A new job, a new car (with only seventeen more payments), and a district of my own!

What had the supervisor said this morning?

"Great Bay Circle is located outside the city limits, facing Great Bay. It is about fifteen miles from the office. About three thousand people of all nationalities live in the Circle. The last nurse spent a year in this district and left three months ago to get married. Since then the district has been shared by the staff nurses. There is a great deal of work to be done, and I know you can do it."

As I drove along I allowed myself a childhood luxury, "painting pictures." The Circle must be a suburb of the city like Coral Gables, a suburb of my home in Miami, Florida. The people would probably be commuters, white collar workers, with small white houses with green shutters, and a small square of grass in front. The backyards, where the children played, would be a riot of color with the usual purple and white petunias, golden nasturtiums, funny-faced pansies, and red and white rambling roses on a trellis. There would be a large ivy-covered stone church where the families gathered on Sunday, some to pray and others to show off their "church clothes." The brick schoolhouse would have large recreation grounds with a tennis court, swings, and seesaws!

The children probably spent most of their time at the beach, Great Bay, romping and squealing gleefully as they ran back and forth into the water, soaking up the sunshine. Some would have their sturdy little bodies clad in abbreviated trunks and others would be covered with their childish exuberance and a good coat of tan.

Oh yes, it would be rather nice working in this district! The families would be eager for health education and would have all needed equipment with which to work.

I put away my "pictures" as I neared the city limit sign in front of the bridge. I would soon be in the Circle. The directions read "cross the bridge and drive about a half a mile." As I crossed the bridge, I noticed a very large building off to the left. I slowed down and looked it over carefully. Could I be right? It looked suspiciously like most of the incinerators I had seen. Well, why shouldn't the district have an incinerator? Wasn't incineration part of public health and sanitation?

I had to drive more slowly now for the fine asphalt road had become a soft dirt road with large ruts and huge holes filled with muddy water. Occasionally I would hit one of these holes and my skin would crawl as I heard the plop of muddy water on my new shining car.

It seemed as though I had been driving for miles, yet actually it was only one mile. There were no houses on either side of the road, only mud, rusty tin cans, several slowly disintegrating "jallopy" skeletons and occasionally a scrawny, half-starved, orphaned maple tree.

Now the road began to narrow, the

gaping holes were much closer together, and the ruts deeper and winding. I began to worry about my axle. The road felt as though it were getting worse and each time I hit a hole it felt as though the roof came down and touched the axle. Just wait until I see that salesman again. "Knee action and extra coils in the springs to cushion the jolts."

I must have taken a wrong turn somewhere. Surely Great Bay Circle was nowhere in sight! This was probably all part of the city dump grounds. Well, a public health nurse should know her community resources, shouldn't she?

I had decided to attempt to turn around when I spotted a very small building ahead. I decided to inquire where I was and how to get to my district. The building was a one-story wooden structure, which had been white at one time, but was now a dirty weather-beaten gray. The front had the appearance of a general store in a rural area. On the left of the door was a show window with the words, "Bar and Grill." There was a dingy-looking curtain hanging from a pole which prevented anyone from looking inside. The show window on the right had been broken and had been boarded up. In black irregular letters someone had printed across the boards, "Soda, Cigars, Luncheonette." There was a swinging screen door, and from within I could hear the voices of men.

I stopped the car in the middle of the rutted road and walked slowly toward the building. Was I taking a chance going into this Bar and Grill? The place didn't look very inviting and there didn't seem to be any other houses around. What was it my father used to say when he was teasing? "Anyone who runs off with you will drop you at the first light!" Smiling at the thought of home, and wondering why I had ever left Florida, I opened the door and stepped in.

On the left side of the room was a long counter with the proverbial brass footrail running along the base. There were two small round tables covered with faded, shabby oilcloth, beyond the counter toward the back of the room. Seated at one of the tables was a woman about sixty years of age. She had a small, round face, and rather narrow gold-rimmed spectacles which rested about a third of the way down a short tiptilted nose. Her beautiful thick white hair was braided and piled high on the back of her head. I marked her down in my mental notebook as "O.K." because of the pudginess of her dimpled arms and the maternalistic proportions of her figure.

The right side of the Bar and Grill was a small grocery store. Behind the counter, a tall, dark, middle-aged man, with large homely features, was waiting on a boy about five. These then were the men's voices! Somehow they seemed less formidable now, as do all our fears when exposed by reason.

The woman looked up expectantly as I closed the screen door behind me.

"Hello, dearie. Looking for something?"

"Why, yes, thank you. Can you tell me how to get to 60 Walnut Street, Great Bay Circle?"

It was the man who answered. "Going down to see Mr. Morris? He's waitin' for you. His son was in this morning to get Mom to call the nurse. Guess he's in pretty bad shape. Been in the hospital a long time. Nearly died to hear his wife tell it. Too bad! He's a fine man. Won't never be able to work again, his son says, but then he ain't worked in the last five years, has he, Ma?"

Mentally I leaped through the pages in the Manual until I came to "Basic Principles." Yes, that's what I thought it said, "Learn all you can about the patient or family before you make the visit." Further down the page another principle stood out, "It is unethical to

discuss a patient or his family with other people." Heavens, if all the statements in the Manual were as conflicting as these two in the present situation, I was really on my own!

I was jerked out of Basic Principles by Ma's voice saying, "Shut up, Kerry, and tend to Jimmy's order!" Then, smiling at me, "You're in the High Grounds now, dearie. Walnut Street is the last street on the left off the main road. You can't miss the Morris house. Look for the spring fence. And child, if you are going to be down in the Circle all day, you had better come back here for lunch."

I thanked her and, more confused, left the Bar and walked back to my car. What was a spring fence? How far from the High Grounds was Great Bay Circle?

As I drew near the car, the sound of sharply excited young voices made me look away from my thoughts, and the picture before me brought me to a halt. Five small boys, about eight years old, were very busy putting finishing touches on a picture of a nurse outlined in white soap on my beautiful new car! The picture was an expression of the hate and disrespect of youth for the authoritarian adult—in this instance, a nurse. The round circle that was the face enclosed two small eyes crossed at just the right point, a wide crooked nose, a hard straight mouth. The hair was sparse and stood out straight. The round, overstuffed body was balanced precariously on two crescent-shaped slender limbs without feet. Branching out horizontally from the upper part of the body were two short stumps, and over the right stump teetered what was obviously the bag of the visiting nurse. Had the picture been drawn on anything but my new car I would have appreciated the story it told.

Calmly and with all the professional aplomb I could muster, I made my presence known by saying, "Don't you think you have made me a little too fat?"

Somebody yelled, "Cheezit, the nurz!", and the scampering began. One brave lad, on turning for a second look at the nurse, stopped long enough to holler after the others who were by now some yards ahead of him, "Hey, this ain't the same one; she *is* skinny!" Still looking at me, he resumed his running and piled up in a heap when he struck a large rut he didn't see. I could see that he was hurt by the puzzled, scared look that spread over his face when he looked down at his legs.

By this time the pages in my Manual were turning so fast I couldn't find the principle I knew wasn't there. I made a mental note to ask the supervisor whether or not new staff nurses might make recommendations concerning additions to the Manual.

I hastened over to the fallen artist and looked at his leg. It was bleeding profusely from an ugly jagged tear above the knee. I stopped the bleeding with my clean handkerchief as a pressure bandage, and invited the boy to ride to his home with me. Very reluctantly and somewhat suspiciously, he took my arm and limped along toward the car, carefully ignoring the other boys who were watching from a safe distance. As I opened the door of the car, the portrait of the nurse came to life as misshapen twins, each standing on one brave leg that supported half a body and half a head. I swallowed hard and tried to smile at the little fellow as I said, "I still think she's too fat."

The little fellow got into the car, and I settled myself comfortably at the wheel, once again feeling the efficient visiting nurse, although as yet I had done no visiting.

I was totally unprepared for the shock which came in answer to my question, "Where do you live?"

"60 Walnut Street. But honest I didn't know you wasn't goin' to be the other one. Pop's waiting for you. He's

sick, and so is Mom mostly. You won't tell on me, will you, nurse?"

60 Walnut Street! That was the first call on my sheet. Could this be Great Bay Circle? But no, it couldn't be. No one had said it was. Turning again toward the boy, "No, I won't tell on you. Tell me, is—is this Great Bay Circle?"

"Yes, ma'am."

I could hear the tinkle of broken glass as the preconceived picture of my district came crashing down over my head. The bright little green and white houses aged rapidly into little gray-looking, wooden structures badly in need of repair. The colorful happy faces of the multicolored, backyard flowers withered and died, and over their graves appeared rusty tin cans. The church, schoolhouse, playgrounds, beach, and even the commuters were damaged beyond repair. The metamorphosis of the children tugged at my heart, and made me forget that one of the basic principles read, "Be sympathetic but not sentimental." The sturdy little figures of the children playing vigorously in the sunshine became suddenly tired, their shoulders drooped, chests sunk, arms and legs became scrawny, and the happy red-cheeked faces became almost entirely large sad eyes set in pale gaunt frames.

"Here it is, nurse" brought me back to the fact that I had company. As I looked in the direction the lad was pointing, I remarked to myself that this was indeed a day of surprises. Here at last was the house with the mysterious spring fence. In the center of a fairly large piece of ground that was covered with ashes stood a very small house which could easily have been mistaken for a good-sized New England tool shed. It was almost square, and instead of glass in the windows there were improvised wooden shutters, which were open. Behind the house was a large garden with luxuriant vegetables growing right out of the ashes. Beyond the garden stood a very small wooden structure with a half moon cut into the door, at the top. Yes, here in the heart of the city stood an old-fashioned outhouse! In the front of the house stood a crudely constructed pigeon house, with several gray and white pigeons sunning themselves on the roof. Enclosing the house and grounds was the most unique fence I had ever seen. It was made entirely of old bedsprings! The springs of various sizes and makes stood on end, and were fastened together with wire. Every five or so feet a large stake served to keep the springs in an upright position. I wondered how one family had managed to collect, in the short span of life, a sufficient number of bed springs to build this bizarre fence. The gate was made of wood and painted across the gate was the warning, "Beware of Dog."

I got out of the car, picked up my nurse's bag, and turned to the boy who was already at the gate. He smiled shyly, "He don't bite, no teeth!" I learned later that the huge, fierce-looking black animal was ten years old, toothless, blind in one eye, and very gentle.

With mixed feelings and as much professional dignity as I could muster, I followed the boy to the house. I hesitated at the door, and a deep male voice urged me to come in. I walked into a small room which was obviously a kitchen. There was a large old-fashioned coal stove, a wooden table, four straight chairs, and a cupboard with dishes, pots, and pans neatly stacked on the shelves.

A door on the left side of the room opened into a bedroom. From the kitchen I could see the head of the bed. A thin, wrinkled face with large, dark eyes and dark hair smiled a welcome, "Come in, nurse. I'm glad you're here. Would you mind doing my dressing? It needs changing and is very uncomfortable. Gene will show you where the water is if you need any."

I set my bag on a newspaper on the kitchen table and followed Gene. Yes,

I thought so, an outside pump! I laughed to myself as I thought of something I had read not long ago. It was about rural public health nursing:

> The nurse in a rural area has very few things with which to work. Rural nursing is more challenging than urban nursing where a nurse has all of the modern conveniences at her disposal.

Surely the author had never been here!

Gene and I carried water into the house and I put on my apron and began to nurse my first patient in my district. As I worked I noticed a beautiful, and certainly very expensive, clock on the dresser. There were myriads of dials on the face, one for day, one for month, barometer reading, and time. The case was mahogany. My comment about the unusual clock unfolded the story of Mr. Morris and Great Bay Circle. The clock and all the furniture in the house were salvaged from the city dumping grounds which I had passed after I crossed the bridge. Mr. Morris had cleaned and repaired them himself and was indeed proud of the clock which was a duplicate of one owned by President Roosevelt.

Had I noticed the fence? It had taken three years to accumulate sufficient material to build it, but it was worth it.

"How long have you lived in the Circle?" I asked, primarily to keep him talking as I started the difficult and painful dressing. This treatment required the removal of a four-inch rubber tube in his back which was inserted through an inch opening into the space between the lungs and the chest wall. The tube served to drain off the purulent material which collected in this space and interfered with his breathing. I removed the rubber tube, cleansed it, and put it in a small basin of water to be sterilized. Looking into the wound, I could see the rhythm of the lung like a giant bellows breathing.

"That's fine, nurse, didn't hurt a bit. Don't be afraid to hurt me. I'm pretty used to this dressing and it feels so much better after it's done."

I was sure, from the remark, that Mr. Morris could see the butterflies that had suddenly appeared in the pit of my stomach.

"Oh yes, nurse, you wanted to know how long I've lived here. Well I've been here ever since there has been a Great Bay Circle. This used to be a swamp about seven years ago. City filled it in after they found the body of the little girl that was murdered some years ago. This here part of the Circle down by the Bay is the Low Grounds. Low, I guess, because it is low, and water keeps coming up through the floor in very wet weather. Up above, beyond Ma Kelley's store, is the High Grounds. No water up there, but rents are pretty high."

I was appalled. These miserable shacks were rented! I started to ask how much rent he paid, then remembered on page 22 of the Manual, "Do not ask personal questions." Plague take that Manual anyway!

"How high are the rents in the High Grounds, Mr. Morris?"

"Well now, nurse, we pay ten dollars a month for this house. That's reasonable, isn't it? Up in the High Grounds the same house would rent for twenty-six or twenty-seven dollars a month."

I tried not to show what I felt as I encouraged him to talk further about the Circle.

"You'll like it here, nurse, if you like real people. Oh no, we haven't very much money, but we get along. Fact is, most of the people are unemployed. I guess that's not strictly true because we have a number of WPA workers who live down here. Nice folks though. You'll like them. They'll like you, too, I think. Last nurse down here couldn't stand us, and I guess the feeling was mutual. Always prying, and always trying to tell you what to do. Folks down here don't like people who don't mind their own

business. The other nurse meant well, I suppose, but she was just naturally one of those people born to be a boss. Took herself seriously. I guess the kids made it pretty tough for her. She used to chase after them, and threaten them with the cops. What she forgot was that she made them just as mad as they made her. Huh, if Ma could hear me, she'd bawl me out for gossiping."

I tried to sound confident as I said, "You haven't been gossiping. I know I am going to like it here very much and I hope the people will like me. Now, Mr. Morris, how does that feel?"

I finished the dressing and bath, and began to pack my bag. Gene, I noticed, had disappeared. I said goodbye to Mr. Morris, and promised to return the next day.

As I walked down toward the spring fence, I wondered how I would be received by "my community." Would these people accept me? Would I make the same mistakes the other nurse made? No, I wouldn't!

Sounds of grunts and groans brought me back to the fact that I was approaching my car. The funny scuffling sounds came from the other side of the car. Gene and another boy were "slugging" it out toe to toe! I watched for another minute or so, and decided that I must do something immediately even though Gene was top man in this bout.

"Hello there. What's going on?" Not a very brilliant remark, but it served the purpose. The strange boy looked up, saw me, and took to the fields. Gene just stood there, panting.

"What was the fight about, Gene?"

A puzzled look spread over his face, and he said in a bewildered voice, "Don't you know?"

"No, Gene, I didn't see anything. What is it?"

He pointed his finger toward the car, and said simply, "Look."

As I looked at the car, my knees became shaky, and the crescendo of my blood pressure roared as it rose beyond the dangerous level. My pride and joy, my new car had four flat tires! I closed my eyes, opened them and looked again at the car. Yes, it was real. The four tires were indeed flat.

"But how? What?" I had the same lost feeling which I experienced many years ago when the bridge on my violin broke, and I thought it could never be played again. My runaway blood pressure which had risen so quickly a moment before began to drop, and the low whine of the diminuendo left me as limp as a deflated balloon.

With understanding far beyond his years, Gene said, consolingly, "They can be fixed. They ain't really flat, only the air was let out of them. Johnny did it, but he thought it was the other nurse. They used to do it to her all the time. I tried to tell him you was O.K, but he wouldn't believe me so I let him have it. He won't touch the car any more, I'll bet."

So he had been defending the nurse. With his hair disheveled, several large red welts on one cheek, and his shirt torn, Gene didn't look very much like a Knight in Armour, but his sincerity shone through his eyes like a light.

Looking at Gene, I realized suddenly that I liked my new district. Yes, I would fight to make the people like me. The flat tires didn't seem to matter very much any more, and the picture of the nurse on the car would wash off. Those things weren't real, but people like Gene Morris and his father were very real. I was very happy at the thought of my district, Great Bay Circle, and public health from then on.

Returning Service Man and His Family

By MIRIAM A. DAILEY, R.N.

SHOULD Uncle Sam see fit to issue a call for second reserve nurses a very sizable group of recruits would waste no time in presenting themselves for active service. Many of the older, more experienced nurses have looked with longing eyes at their younger colleagues who have answered the call of the Army or Navy Nurse Corps, and would have been "off to the wars" themselves if an opportunity had been offered. Not only has the home front looked less glamorous, but unchanging routines of the daily duties have seemed so far removed from war activity that many nurses have overlooked the important contribution they are making to the war effort. Particularly is this true of the public health nurses. In the past several months, however, they have been confronted with many health problems which are the direct result of the present world conflict, and many of the nurses have come to the realization that the home front is very important after all.

The public health nurse is only one factor, however, in the solution of these vital health problems. Certain family situations require expert handling by well-qualified social workers and the close cooperation of both nurses and social workers in providing adequate health supervision. In New Hampshire a plan of cooperation is being formulated by the Health Committee of the New Hampshire Conference of Social Welfare which, it is hoped, will bring about a more complete follow-up of all cases needing health supervision, and elimination of duplicated effort on the part of the health and social workers. The committee is composed of the health officer of the State Department of Health, the deputy health officer, the executive secretary of the New Hampshire Tuberculosis Association, the supervisor of health of the State Department of Education, the director of Mental Hygiene Clinics of the State Hospital, the superintendent of one of the general hospitals, and the executive director of a visiting nurse association. The experience of these four physicians, two nurses and a hospital administrator presents viewpoints from several fields of health work, from both official and non-official agencies. The activity of the committee has centered recently on a study of the degree of adequacy of all health facilities within the state, with a view to some definite recommendations to the New Hampshire Conference.

Believing that the business of most immediate concern is the responsibility toward the returning service men and women, the committee presented a health section program at the annual meeting of the Conference early this year. Because of transportation difficulties many public health nurses were unable to attend this meeting, and the committee complied with a request from the nurses to repeat the program at a quarterly meeting of the Graduate Nurses Association of New Hampshire.

By quizzing a number of social workers it was learned that the majority of them had a very vague idea of the functions of many of the health agencies in the state, and of which agencies were best equipped with the health services needed by the medically discharged service men and women. In order to eliminate

duplication of effort on the part of social workers and public health nurses, and to save valuable time by direct referral to the proper agency, pertinent information regarding health agencies was presented in the conference program.

The topic of the symposium was "Integration of Health Services for the Returning Service Man and His Family," and the discussion was divided into two main parts (1) facilities for medical and nursing care (2) facilities for health education and rehabilitation. By way of introduction the acting state health officer reviewed some of the facts concerning the diseases not prevalent in this country, but which may become problems as more men return from service in tropical regions. This was followed by an outline of the responsibilities and clinic facilities of the State Health Department, including the emergency maternity and infant care program for wives and children of service men.

The second speaker was the regional chief medical officer of the Veterans Administration. He discussed the facilities available after patients are discharged from base or veterans' hospitals and still need follow-up care.

The assistant field director at Grenier Field (the Army Air Base in Manchester), a psychiatric social worker who is usually present at the medical conferences, is familiar with the cases coming up for medical discharge. Her contribution to the program was two-fold, as she spoke not only of the conditions leading up to discharge from service, but explained the function of the Home Service Department of the many Red Cross chapters, whose direct responsibility is to the service men and ex-service men and their families.

The place of the private agency in supplementing the work of the public agency was stressed by the director of rehabilitation of the New Hampshire Society for Crippled Children and Handicapped Persons, and the functions of this agency were outlined.

One of the highlights of the program was the address by the director of the Mental Hygiene Clinics of the State Hospital. From this psychiatrist's point of view, the public health nurse has a better opportunity than any other health or social worker to uncover serious emotional disturbances, and to make an outstanding contribution in helping to correct conditions in their correctible stages. The speaker presented a very moving appeal to the nurses for their assistance in interpreting to the families the changes which occur in psychoneurotic cases and the need for sympathetic understanding in dealing with them, also the changes which are taking place in family relationships because of war conditions. The need was also stressed for close and competent follow-up of these patients. Because of the very large number of medical discharges for psychoneuroses, the nurses will have many opportunities for this kind of service.

The final speaker, a member of the nursing staff of the New Hampshire Tuberculosis Association, made a splendid contribution to the program with her paper on teaching our families with "An Understanding Heart." Clearly defined methods of winning family cooperation were both appealing and stimulating, and were vivid reminders of the basic principles of teaching.

In summarizing, the leader of the discussion emphasized three needs:

1. To clarify our thinking generally regarding functions of health and social workers, and the relationship of each to the other.

2. To avoid duplication of effort in handling cases.

3. To secure better organization of community resources to meet existing needs—more adequate health facilities, and more well prepared social workers and public health nurses.

The Public Health Nurse and Her Relation to Authoritative Agencies

By HELEN V. STEVENS, R.N., AND SYBIL H. PEASE

AMERICANS are especially sensitive just now to the overtones and the interpretation of that word "authority,"—just now, when the enemies we fight represent a philosophy of power, undiluted by love or pity, power rampant. It is impossible to write unemotionally about it, and we may well pray that it always will be impossible for an American to be unexcited about the matter of who has authority, and what is being done with it; and if it is misused, what can be done about it. To be emotional about authority, however, does not preclude the possibility of doing some thinking on the subject. In fact, just because it does arouse so much emotion, thinking about it is all the more necessary.

The dictionary gives "legal or rightful power; jurisdiction" as its first meaning for "authority" and that is the one adopted for the purpose of this discussion. The great majority of citizens, probably 95 percent, intellectually accept the fact that there must be regulations and someone to enforce them. That is, the citizen's official, best-foot-forward attitude toward authority is that of a law-abiding individual. His private, often unconscious attitude is that the laws are made for someone else and that when a law inconveniences him, he may evade the law. Examples of this attitude are too numerous and too well known to need repeating. Traffic regulations, hoarding of food, "blackmarket nylons" bring examples not too far from home to the mind of every one of us.

The attitude which the public health nurse brings to bear on this subject and all of its implications is a complex of her own individual background, standards of her family and social group, as well as what her educational and practical experiences have been prior to and during training.

There are almost certain to be factors in her personality and in her professional training which, to an extent, predispose her against the use of authoritative action. The fact that she has chosen a vocation that demands so personal and self-sacrificing a service indicates her interest in and liking for people, as well as a tendency to identify herself with those whom she serves. In her hospital training, she has been exposed at some time or other to the more sordid aspects of life, together with high concepts of service to even the lowest and meanest, most fractious and unruly. Nursing ethics has given her the ideals and traditions of a profession with an almost religious degree of charity toward those whom she serves. At the same time, ethics dictates a recognition of and respect for authority and discipline. What her individual experiences have been with head nurses and physicians largely determine her identification with or rejection of authority. Sociology, psychology, and psychiatry have helped to interpret human frailties and their causative factors and may have given her some self-knowledge as well as an intellectual understanding of behavior.

THE PUBLIC HEALTH NURSE with these variables in background and individual attitudes, learning the new community approach, is largely governed in what she does in meeting situations in homes and the community where she works, by the policies which have been adopted by her organization and by the direction and help given by her supervisor until she, too, incorporates these policies and advice as a part of her working equipment. She learns that one measure of her progress and growth is her ability to teach and to motivate people, to gain the respect and confidence of her families; that she is expected to be able to recognize and analyze conditions that are outside the law and to steer her course both as professional and as citizen between the Scylla of the community and the Charybdis of the individual. Perhaps she eventually learns to see her own patterns clearly enough that she can do this without undue worry and struggle. Perhaps she never learns to accept wholeheartedly the dictum that "What is not good for the hive is not good for the bee," believing that while this may be true in the insect world, it does not apply to humans. On the whole, however, she does learn that a higher value is placed on her skill as a health teacher and guide than on strong arm methods. She learns that the aim of the nursing agency is to reach those who need the skill and knowledge of the staff nurse and that open doors and a ready entree must be kept for her. She is there to render a specialized service, not to enforce an ordinance. This is not to imply that the nurse lacks initiative or aggressiveness when her responsibility for a health situation is at stake.

In the history of the anti-tuberculosis program and in the present intensified syphilis control program, we see the health authorities and the official agencies resorting to every means of control before legal coercion is used. In the public health field, with all of the legislative permission of police power, a situation has to be serious indeed before a representative of law enforcement is called in. This surely is as it should be, since we know that approach to the patient from the standpoint of protection of his health is more productive of results than is the negative approach through fear. "It cannot be reiterated too often that the way the patient feels about having syphilis is one of the most important factors in syphilis control. An authoritative approach has real value when other methods fail, but experience has shown that it seldom holds the patient to regular, continuous treatment over a long period, nor is an authoritative approach likely to make the patient an educational agent for a syphilis control program."*

If this is so in public health, it is even more true in public health nursing, where the nurse's privileged status is so similar to that of the family physician. And yet, the emotional heritage from the pioneers of nursing, together with her knowledge of epidemiology and hygiene, have given her a social conscience which will not let her "rest easy" unless she includes in her concern all the other families whom she does not yet know—that collective organism known as the community.

A BRIEF INQUIRY into the practice in use by the Public Health Nursing Association in three different areas of Allegheny County shows similarities and differences in the relationship of the nurse with authoritative agencies, and seems typical enough to serve for the rest of our 11 substations. One of the city bureaus, of which the staff is very conscious, is the Bureau of Inspection under which is the Division of Housing and Sanitary Inspection.

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*Kresge, Alice M. "A Technic of Follow-up of Selective Service Registrants with Syphilis in Philadelphia." Venereal Disease Information, June 1944, p. 167.

Pittsburgh has made great strides lately toward better housing but some of the facts reported by the 1935 Social Survey are still lamentably true. A conservative estimate is made that about 18 percent of the housing, including Pittsburgh and the County, is in need of major repair. The public health nurses visit many families who live in such dwellings. Reports on insanitary and unsafe conditions are channelled through the Pittsburgh Housing Association to the Division, and scarcely a day goes by without a report in regard to the broken steps in a house on Slum Street, or the defective plumbing on Uneasy Street. About three fourths of the reports on housing violations and kindred matters which reach the Housing Association are made by the public health nurses.

A resource which occasionally meets a very urgent need is the Humane Society, chiefly in cases where an adult patient is being neglected by his family to the extent that common decency is violated, and there seems to be no other method of correcting the situation.

It should be noted that this county has 126 separate governmental units and that there are 243 aldermen and justices of the peace who are responsible for the dispensing of justice in a large proportion of these units. Besides the City of Pittsburgh, the County includes 3 cities, 69 boroughs, 24 townships of the first class and 29 townships of the second class. It has been well called a "political crazy quilt." The total population is upwards of one million and a half. That the zealousness of law enforcement officials everywhere is a variable quantity is a well-known fact. Presumably, citizens, on the whole, get just about what they demand along these lines. Obviously, the basic setup mentioned above means even more than the usual variation in the character and zealousness of public officials.

The brief inquiry mentioned above covered two boroughs and one section of Pittsburgh. In one of the boroughs the Association's office is located in the borough building, over the fire station and the police office. A very cordial and wholehearted variety of cooperation has grown up between the officials and the nurses, with the police turning to the nurses when they have a problem involving children, and the nurses turning with equal relief to the police in certain emergencies. Last winter, for example, an elderly woman was badly burned. When the nurse came she learned that the patient, Mrs. S., was psychotic and in need of institutional care. The police agreed to arrange this and to furnish transportation, and in a very short time, through their excellent cooperation, Mrs. S. was safely ensconced in the appropriate hospital, with the very minimum of "red tape."

THE OTHER borough office was deeply concerned over a very serious situation which came under the jurisdiction of the local constable. Recourse was finally had to the State Police as no action was forthcoming locally. The State Police immediately referred the situation to the County Juvenile Court. The case involved five children and their parents —all seven with positive serology for syphilis. The nurse, the casework agency, the relief agency, the truant officer, and other agencies had been working with meager results for several years. They lived some distance from the hospital, and the total number of treatments for all seven in one year was 22. The neighbors became alarmed for their own safety, as well as for the children in the family, when the father began to "act queer" and the climax came when he killed a mother dog and her litter with so much brutality that the neighbors recognized the act as abnormal. The court worker acted immediately to remove the children from danger and to see that they had the needed treatments.

An example from the city district shows a variant of this situation, and shows how impossible it is to lay down inflexible rules in regard to cooperation. In this case, there was disagreement between the casework agency and the nurse, based upon one of the fundamental differences in point of view between the agency which does a highly selective job and the one whose aim it is to come as near as possible to reaching every man, woman and child in the community who needs health care. In this case an infant of 18 months weighed nine pounds and the mother was admittedly neglectful, although she was making some effort. The nurse felt no time should be lost in removing the baby from the home if its life were to be saved; the agency felt that other babies had priority on its few and precious foster homes. The nurse brought the matter to the attention of the Juvenile Court and at about the same time two neighbors of the family also discussed it with the Court and were willing to file a petition if necessary. The Court's decision was that the baby must be removed and it was taken to the Detention Home. It might be said here parenthetically that we feel there is value for the community in the two fundamentally different viewpoints of case worker and nurse; that they supplement each other and do not in the least mean that there cannot be agreement and respect, provided there is acceptance of the difference.

IN GENERAL, it goes without saying that each situation demands the most careful consideration in order that every angle may be covered. Sometimes, of course, matters have to "get worse before they can get better;" sometimes the steam of public opinion has to collect before it is wise to take action "Hindsight" is proverbially clearer than foresight, and should help us, gradually, to regulate our "timing" and increase our wisdom in the use of this tool of legal authority. Informal discussion with the Juvenile Court about situations before the emergency stage is reached is being increasingly used by our staff, and we hope for an extension of this method with other legal agencies.

A worker in the community gets the same excited feeling when she sees evidence of a real change for the better in the community's ways of doing things, as does the worker in a research laboratory when an experiment succeeds. Things *do* move, attitudes *do* change. They move, not with glacial slowness, but more as the ice in a New England mountain brook melts in the spring of the year, little by little and here and there.

THE IMPACT of the thinking about the community's responsibility for attempting to understand juvenile delinquents has been felt in this county. The workers who deal with these children and their parents are more and more able to express this thinking by their own sincere and friendly attitudes. The Juvenile Court more and more has the aspect of a friendly, firm parent who is hoping for a chance to commend, rather than a stern one looking for a chance to punish.

It is not only the young offender, but the adult delinquent as well, who is beginning to get the added help which comes from the more enlightened way of thinking and acting. Women who are on parole are referred to the nurses for health care, especially in one City district, because the parole worker believes that the warm, informal interest of the nurse is one of the ways of expressing society's friendliness in concrete form. The nurses have noticed for some time a very definite change in the way in which the parolees refer to their parole officer, which testifies to the effectiveness of the change.

But communities are thinking not only of understanding and helping delinquents, they are thinking perhaps more

seriously than ever before about preventing asocial behavior through prophylaxis. If, as seems quite likely, this interdependence between the nurse and the law-enforcing agencies increases, we may look for a development in the public health nurse's community responsibility which will naturally and inevitably make her one of the community's agents of prevention not only for diphtheria and whooping cough but also for asocial behavior. It is now a platitude to say that the roots of such behavior are found in the experiences of the child in his infancy and his preschool years. To reach as nearly as possible every child in the community, recognize danger signals, give what help it can, and crusade for further resources, may well be one of the postwar goals which public health nursing sets for itself.

WRITING as we do from the private agency point of view, we probably reflect the traditional approach to situations. The private agency, without official authority, was a pioneer in many health fields and used persuasion, information, education, aggressively, to invoke public opinion, to arouse crusades against disease and health hazards and to bring about reforms. Initiative, a degree of impatience, persistence and courage were needed to launch demonstrations in many of the fields of public health nursing. During the past few years we have seen a shift in the nurse's caseload. Typhoid fever and diphtheria are disappearing while geriatrics, psychosomatic medicine, and health education are coming to the fore. Given her unique opportunity and the proper preparation, the public health nurse should be increasingly effective in the closely related field of prevention that has to do with behavior, with the making of happy and useful members of society. Public health nursing is still pioneering.

Nursing Council in Peacetime

(Continued from page 549)

The Joint Committee on Community Nursing Service of the ANA, NOPHN, and NLNE under the sponsorship of the NOPHN, which was formed in 1935, became dormant during the period of activity of the NNCWS. It has recently become active to perform the job of bringing up to date the schedule for surveying community nursing service. (See "Community Planning for Peacetime Nursing Service," by Alma C. Haupt, page 550.) It can be taken as axiomatic that the first step toward building for the future is the taking stock of present assets and liabilities. Stock-taking is a natural function of local nursing councils, with aid from a strong central organization. The survey schedule should prove a useful device in performing this function.

Local councils may also feel the need for aids of other kinds from national sources and we hope they will be articulate about them.

There is every evidence that a national governmental health plan including medical and nursing care is in the offing, in addition to the voluntary plans which do not yet include home nursing. An NOPHN resolution adopted in June 1944 at the biennial convention stated that the NOPHN "favors the expansion of prepayment health insurance plans with provision of nursing service, including nursing care in the home. It believes that, in addition to voluntary effort, governmental assistance is necessary to attain adequate distribution of health services."

More recently, at its second annual war conference, October 1944, the Governing Council of the American Public Health Association adopted as a statement of Association policy a report of its Committee on Administrative Practice—"a set of principles expressing the desir-

(Continued on page A10)

A Statewide Immunization Program

By ABBIE R. WEAVER, R.N.

AT A RECENT meeting of a small group of nurses in Washington the discussion turned to changes in the services rendered by the public health nurse which might logically be expected in the postwar period. The opinion was expressed by one member of the group that certain activities long considered to require the skill of a physician might be delegated to the nurse because of a continued shortage of medical personnel and also because the public health nurse had, during the war emergency, demonstrated her ability to perform these services in a satisfactory manner. One of the activities especially mentioned was the administration of vaccines. This statement caused the writer some surprise in view of the fact that not only the administration of vaccines, but many similar procedures, had long been considered routine nursing activities in Georgia. A few weeks later, when a public health nursing supervisor from one of the Canadian provinces, who had been spending some time observing the public health program in Georgia, remarked, "I am amazed at what rural nurses are doing in Georgia; such procedures are unheard of in my country," I realized that perhaps our experience was really unique and would therefore be of interest to other areas.

For the last ten years public health nurses in Georgia have administered all types of vaccines. The story of how this service was established has its beginning in the grim days of the depression in the winter of 1934. At that time the State of Georgia was almost devoid of public health nursing service. Only some 30 of the state's 159 counties had organized health departments and only 16 of these counties had been able to maintain a public health nursing service. There were, however, hundreds of graduate nurses in Georgia who were in dire need of employment.

Jane Van De Vrede, a registered nurse, had been appointed state director of women's work projects under the Civil Works Administration and continued to serve in that capacity through the FERA and the WPA. Miss Van De Vrede was and is well known to southern nurses. During and after the first World War she had served as the director of nursing service for the southern division of the American Red Cross and later held the position of joint secretary to the Georgia State Nurses' Association and the State Board of Nurse Examiners. Through these two positions she had acquired an intimate knowledge of nurses and nursing needs in Georgia. In her capacity of director of women's work projects she felt a deep concern for the large group of unemployed nurses and immediately turned her thoughts to providing some type of project which would meet their need for employment and also provide a very useful community service. After a conference with Dr. T. F. Abercrombie, state director of public health, a project was drawn up sponsored jointly by the Federal Children's Bureau and the

Georgia Department of Public Health, and I was asked to put the plan into operation. This project provided for the assignment of 42 staff nurses and 4 supervisors to the Georgia Department of Public Health for a period of three months. These nurses were to be drawn from among those who had been certified for work relief. In reviewing this list it was found that few of these nurses had had either preparation for or experience in public health nursing. The program adopted, therefore, had of necessity to be limited to the simplest activities. After careful consideration just two objectives were decided on: (1) the recertification of midwives, (2) a survey of tuberculosis deaths for the past five years and the location and study of contacts. This program seemed simple enough, but in its actual execution, it was found that the nurses had to be taught several new nursing procedures.

There were some 3,000 certified midwives in Georgia who had not been seen by a public health nurse for over three years and many others who were waiting to be certified. The law regulating the certification of midwives required that each midwife be vaccinated for smallpox and that she have a blood test for syphilis annually. Therefore, the nurses assigned to this project became responsible for vaccinating a large number of this group. They also took a specimen of blood on practically the entire number, to be sent to the state laboratory and tested for syphilis.

The tuberculosis program started with visits to the homes where there had been a death from tuberculosis within the past five years and to patients who had been dismissed from the State Sanatorium within that period of time. The nurses were provided with the name and the last known address of each of these families. When the families were located it became a part of the nurse's responsibility to secure histories on all contacts; to administer and read the tuberculin test; and to schedule positive reactors for a chest x-ray at clinics which were visited by a healthmobile equipped with a portable x-ray.

The nurses who served on this project were called into the State Department of Health in Atlanta for two days of instruction before being assigned to their respective districts. This instruction included a demonstration on how to vaccinate for smallpox, how to take a specimen of blood for a serological test, and how to do the tuberculin test. These demonstrations were followed up by individual instruction in the counties to the nurses by local physicians, health commissioners, the regional supervising nurse, and, in the case of tuberculin test, by a full-time physician from the State Department of Health. It was in this manner that a precedent was set in Georgia for public health nurses to perform certain routines usually considered to fall within the province of a physician.

At the end of three months the project was extended. It operated continuously for over two years and at its peak gave employment to 194 nurses. With the increase in the number of nurses assigned to the project new activities were added to the program, important among which were the organization of immunization clinics and the administration of typhoid and diphtheria vaccines. In assuming these responsibilities it was necessary not only to have the approval of the physicians of the state but the actual authorization for this service by some physician or group of physicians to cover the activities of each individual nurse. It was obvious that a nurse could render such service only as the authorized representative of a physician. In the absence of standing orders for public health nurses the Medical Association of Georgia was asked to give consideration to the part the public health nurse should play in a

public health program. The president of the association appointed a special committee which, after three meetings, drew up a statement known as "Approved Nursing Service Policy." These policies were submitted to the State Medical Association as a whole and unanimously approved. Following are extracts from the policies relating to the nurse's part in communicable disease control:

> The nurse in her educational work may promote a county-wide vaccination program against typhoid fever, diphtheria, and smallpox. This program should first be started in the public school system and in sections where these diseases are prevalent. Before attempting to establish an immunization clinic, approval of the County Medical Society or the County Board of Health must be secured. It is necessary that some physician in the community where the clinic is to be established be appointed to assist or supervise the establishment of such clinics and be present or assume the responsibility of holding such a clinic. The nurse may administer vaccine when approval is given by the County Medical Society or when the majority of physicians of the county give their approval in writing.
>
> Vaccine must be administered only in groups at clinics as approved in the above paragraph and the nurse is not to administer vaccine in isolated homes except upon written request of some physician.

The State Department of Health provided a form to be used by the local physicians in authorizing nurses to administer vaccines. This form is still in use. When signed by the county medical association or a physician or group of physicians, it is sent to the State Department of Health and filed in the laboratory for reference at all times. Vaccines are mailed to the public health nurse upon a requisition signed by her. The order is not filled, however, unless the authorization signed by a physician or physicians is on file. This authorization is valid until cancelled by the physician or physicians who signed it.

In isolated sections of the state, especially in the mountainous areas, travel to clinics or health conferences is difficult even in normal times. In such counties the administration of diphtheria toxoid to infants and preschool children has become a routine part of a nurse's home visit.

During the two years and four months the work projects were in operation, nurses in Georgia gave close to 500,000 doses of vaccines and completed over 18,000 tuberculin tests.

When this project closed in 1936 and a permanent nursing service was established, the administration of vaccines by the public health nurse had become an accepted routine throughout the state and with each succeeding year the immunization program has been increasingly entrusted to the public health nurse. Within the past year the administration of pertussis vaccine has been included in her activities. The following figures show the total number of immunizations and tuberculin tests completed by official health agencies in Georgia during the year 1943 and indicate the percent of each administered by public health nurses:

Immunizations completed	Total	Percent administered by nurses
Smallpox	77,304	86
Diphtheria	46,312	76
Pertussis	9,552	90
Typhoid fever	295,098	91
Tuberculin tests	20,655	84

The intensive immunization program which has been provided throughout the state has played an important part in the gradual reduction of deaths from diphtheria and typhoid fever during the past 10 years—a reduction in deaths from typhoid fever from 316 in 1933 to 23 in 1943, and from a rate of 10.5 to 0.7 per 100,000 estimated population; and a reduction of deaths due to diphtheria from 188 in 1933 to 47 in 1943, and from a rate of 6.3 to 1.5.

It is apparent that the time required to organize the immunization clinics and to play so large a part in the actual administration of vaccines could not but

make serious inroads on the time the public health nurse has at her disposal for other activities, especially home visiting. During the past year the work of the public health nurse has been supplemented by that of the clinic nurse who has assumed the responsibility for setting up and dismantling of clinics, the care of equipment, some record keeping, and the actual administration of vaccines. In the large urban health centers these nurses have served on a full-time basis and in rural counties on a part-time basis; these part-time assistants are usually married nurses whose homes are in the community and who have but a limited amount of time to devote to professional work. On January 1, 1944, there were employed in Georgia 17 full-time clinic nurses and 101 part-time clinic nurses.

In addition to administering immunizations, the public health nurses in Georgia make and read the tuberculin and Schick tests, take blood for serological tests, give bismuth and sometimes arsenicals in venereal disease clinics, administer anti-rabies treatment, make thick blood smears in malaria surveys and take an active part in epidemiological investigations. These procedures are all covered by standing orders or are carried out by a nurse upon authorization of an individual physician. If the services described in this paper become increasingly nursing procedures, it would seem very necessary that instruction and experience in these fields be included in the basic curriculum and also covered by a unit of instruction in the postgraduate course in public health nursing.

GEORGIA DEPARTMENT OF PUBLIC HEALTH
ATLANTA, GEORGIA

Authorization for the Nurse to Administer Vaccines

Date..... Place..... County.....

I authorize the public health nurse to administer the following vaccines in the above named community or communities.

	Check
Typhoid	
Smallpox	
Diphtheria	

Signed.....

Note: The Nursing Policies of the State Department of Public Health permit a public health nurse to administer vaccines only upon the written approval of the County Medical Society or of a majority of the physicians practicing in the community in which the service is to be rendered.

The Nurse in Industry Organizes against VD

By PERCY SHOSTAC

PART II

WORKING closely with your firm health and safety committee, which I will suggest that you organize and will tell you about in detail further on, I am convinced that you will be able to overcome any resistance which employees may have to an educational program on VD. This employee-management committee also will make it easier to get full cooperation for blood tests of all employees. However, no matter how eloquent the selling talks, workers will not accept mass blood tests if they have the slightest fear that those found to be infected will face job discrimination or that their condition in any way will be made public. It thus becomes necessary that management agrees to adhere to a set of carefully worked out employment practices in regard to venereal disease findings and that employees are convinced of its sincerity by being partners in this agreement.

The laws of most states protect the confidential nature of venereal disease information as regards the individual. It is of utmost importance that the results of a blood test (and a medical examination) be considered confidential between the worker and the plant physician. This provision, of course, does not exclude the physician to whom the worker is referred for treatment or the health authorities in states where reporting of venereal diseases is legally required. If you keep your usual clinical records in an open file available to non-medical personnel, separate venereal disease forms should be used and filed in your dispensary or medical department for the use of the medical staff only.

EMPLOYER MUST NOT KNOW

The conditions governing employment should be carried out through the plant physician, who will make recommendations to the personnel director on the basis of the patient's condition and his adherence to prescribed treatments. The employer will not know which of his employees is infected, since, as already stated, this is a confidential matter. Enforcement of this principle is of utmost importance. Violation of confidence and use of blood test findings for job discrimination can undermine industrial health programs and frustrate management's efforts to promote well being and advance efficiency of working crews.

A couple of years ago Surgeon General Thomas Parran appointed an Advisory Committee on the Control of Venereal Diseases in Industry. This Committee after exhaustive study and investigation drew up a fair employment policy which is accepted as authoritative:

I. *If a person has infectious syphilis or gonorrhea,* he or she should be:
   A. Referred to a private physician or clinic.
   B. Returned to work or employed when rendered non-infectious. (A

People can't safely hide their eyes to some things, as that ostrich-like gentleman is about to learn the hard way; syphilis and gonorrhea are among the things that can't be hush-hushed out of existence

few treatments will usually render most cases of syphilis non-infectious.)

C. Told that continuance on the job depends on seeing treatments through to completion.

II. *If a person has non-infectious VD,* he or she should be:

A. Referred to a private physician or clinic.

B. Retained on the job.

III. *If a person is found to have late manifestations of VD,* the treating physician should recommend that person for a job he is physically and mentally capable of doing with safety to himself and his fellow workers.

You are probably wondering why it should fall on your shoulders to combat the indifference and opposition which the enforcement of these fair employment practices will often meet. These practices are indispensable to employee acceptance of your program and it must be your job not to give an inch of ground in their enforcement. You may have to stand up against your employer and to counteract the few casualty insurance companies who still insist that men infected with syphilis or gonorrhea must be fired or not employed.

Naturally if your firm employs a plant physician he will carry the principal responsibility. If he is merely on call or serves on a part-time basis or if he is a doctor who keeps his nose close to the grindstone of his practice, you may have to call his attention to this responsibility. In any case, as already pointed out, it is you who are in closest contact with the employees and you to whom these men and women most naturally will turn first. And you can always count on the advice and guidance of the plant physician. He may refer you to the local health department to help solve especially difficult problems.

A SACRED TRUST

Can't you imagine yourself gaining the confidence of a worker infected with syphilis and saving the health of a family by interpreting the situation sympathetically to his wife? Don't you see that such opportunities truly to help your fellow human beings are likely to come up day after day if you are receptive to them and equal to them? Don't you realize what a source of inner satisfaction such service can hold?

Despite the fact that your livelihood comes from management your ultimate loyalty must always be to the men and women you serve. To fulfill your trust as a nurse in industry you must not only look after your technical proficiency but you must study and understand the needs, the problems and the aspirations of the workers with whom you are associated.

TRADE UNION FUNDAMENTALS

Whether your firm is unionized or not you should understand the trade union movement and what it means and has done for its members. To begin with, it must be recognized that almost fourteen million men and women workers are organized into trade unions in the United States. With their families they constitute a large section of our total population, a group

furthermore with whom you as a nurse in industry will sooner or later come in contact if you have not already done so. This group is also the unofficial spokesman for all men and women who work for a living. Through its activities and influence organized labor has raised the living standards and well being of all workers.

All of us should recognize that men and women join unions in order to better their working conditions and gain greater security, and very rarely because of coercion; that the labor movement has become a vital part of our democracy; that, generally speaking, union members make up the most socially-aware group of our working population; that trade unions hold closed shop contracts covering leading artists of the theatrical and musical professions, top-notch newspapermen, professional people of many categories, the conductors and locomotive engineers on our trains, as well as men and women who work for a living with their hands or minds in most occupations.

The trade unions have long been centers of educational and welfare activities. They have provided insurance and death benefits for their members, and in some instances medical services. Labor history discloses that the trade union movement was a pioneer in the cultural-educational field for the common man; that as early as 1830 the unions played a decisive role in the winning of free public education. While the primary efforts of the unions are for the economic welfare of their members, today they must also be recognized as an important influence in the country for our future development along cultural lines and in the field of health protection and social welfare.

THE MAIN DISH

Now that the general background information has been put on the table, including a few words which indicate the importance of labor cooperation in the health field, it is in order to bring on the main dish.

The program which follows will not fit all industrial groups to a T, but experience has shown that any effective plan must be based on these three essential points: (1) *Organization*—to set up the machinery needed to make the program work (2) *Education*—to drive home the facts about VD and other health subjects to your employee group, and (3) *Participation*—to stimulate employee action for better health for themselves and their communities.

These three points will now be detailed and developed in outline form.

Three-Point Program

I. Organization

No program—regardless of how good it sounds on paper—is going to get to first base unless it provides the machinery needed to make it click with the employees. Employees are bound to react more favorably toward health education and medical services when they have a say, together with management, in organizing and applying the program. Such teamwork can be best accomplished by a functioning health and safety committee in the firm. This in no way minimizes the importance of having one live-wire individual initiate the program and spark it along continuously—and that person might very well be the nurse.

Shop Health and Safety Committee. The Shop Health and Safety Committee should be composed of employee and management representatives, plant physician, nurse and personnel director. The Committee can be organized by a preliminary planning conference which you can be instrumental in bringing about.

The employee members of the Committee should be people whom the workers regard as their leaders, and it is advisable that an employee be elected as chairman. At the first regular meeting, top management should give the program its blessing and make the Committee conscious of its value to employer and employee alike.

Where such a Committee is set up and functioning, it is the basis for getting the program across to all the employees: dis-

tributes literature, sponsors films and meetings on health and safety, and promotes the other activities described in the subsequent sections of this outline.

Through the Health and Safety Committee, several additional developments are possible:

1. The program is taken up on a plant-wide basis, and a spirited and wholesome competitiveness can be set in motion among the various departments to chalk up the best health and safety record for the reduction of absenteeism and the maintenance of uninterrupted earnings.
2. VD control measures, as well as all other phases of the firm health program, are more likely to succeed where other efforts have either failed or have achieved only minor results.
3. Cooperation with local health departments, local social hygiene societies and other voluntary health agencies can be more effective.

II. Education

Education is the cornerstone of preventive medicine. Intelligently warned and informed men and women take the necessary precautions to avoid health hazards or seek early treatment when illness occurs. Education encourages more extensive employee acceptance and utilization of existing medical services and facilities in the plant and in the community. Here are some proven methods of bringing health education to industrial groups:

A. *Articles in Plant Newspapers.* A series of seven articles, "Stamp Out VD," has been prepared especially for plant newspapers by Walter Clarke, M.D. This series, including mats of illustrations, is available without cost.

B. *Weekly Mimeographed Health Bulletins.* If a firm has no publication of its own, a health program can be stimulated by means of a weekly mimeographed newsy health information sheet under the auspices of the Shop Health and Safety Committee. Getting out a sheet of this kind is a splendid opportunity for developing a corps of employee correspondents and can provoke loads of comment and interest.

C. *Movies and Speakers.* Some firms are bringing good films and interesting health authorities (who answer questions) to their employees. Attendance records are best when films and talks take place at regular shop meetings on health on company premises and on company time. Lunch hours and rest periods can also be used for this purpose.

Modern moving picture projectors produce clear images on a screen even if the room is not in total darkness. Firms which do not own a projector may be able to borrow one from their local health departments or voluntary agencies. Film showings and talks often can be arranged without cost through these same organizations.

D. *Distribution of Literature.* Members of the Shop Health and Safety Committee should see to it that pieces of literature on VD (and other health topics) get into the hands of all the workers. Reliable pamphlets arm people with information necessary for their health protection; impress upon them the danger of promiscuous sex relations; guide them to seek regular check-ups; make them realize the importance of immediate medical attention when trouble seems to be brewing.

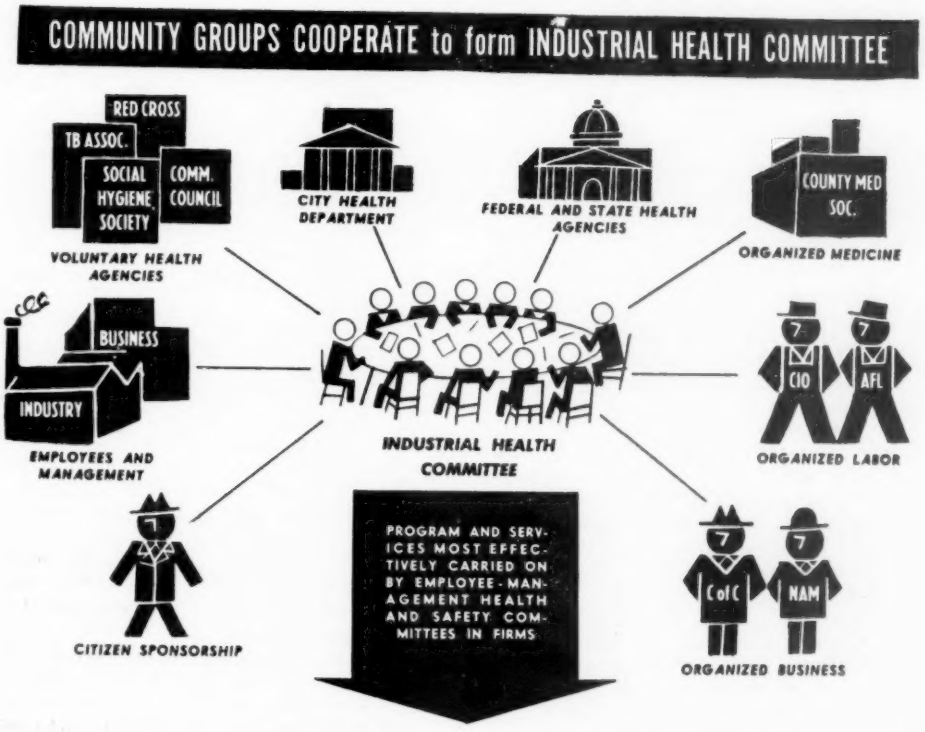
E. *Poster Displays.* Local social hygiene societies and health departments often can provide posters. These posters, carrying a message with an industrial punch, are suitable for display on bulletin boards and in rest rooms.

Widest interest and attention are obtained when posters are changed at fixed intervals and when they deal with health subjects and campaigns highlighted in current issues of the plant newspaper or mimeographed bulletins. Posters on VD can be displayed to best advantage while the series of articles, "Stamp Out VD," is appearing in the plant paper.

III. Participation

Participation in programs for better health, promoted and directed by the Shop Health and Safety Committee, comes under two headings: activities inside the plant or firm and those in the community.

A. *Plant Activities.* When the employees attend movies and talks, read literature and discuss it, in short, when they are reached by the educational program, they are participating in plant activities. Once on the move, the employees are bound to turn in greater numbers to the medical services already available in the shop. They will also be



This chart shows the line-up of forces comprising the Fort Greene Industrial Health Committee in Brooklyn, New York; the program outlined by Mr. Shostac is not as all-inclusive, and can be organized through the initiative of industrial nurses

receptive to, and are likely to request, broader activities.

1. *Referral Service*
   The health and safety committee, as it gains recognition, will receive requests for help from employees with medical, family, welfare, legal and other problems. The nurse must be equipped to refer each case to private physician, hospital, clinic or other suitable agency.
2. *Blood Tests, X-rays, Check-ups*
   Shop-wide blood tests and examinations to help find cases of syphilis become possible when sponsored by the health and safety committee, if a preliminary agreement has been reached between the employees and management safeguarding the jobs of those found to be infected. (See Fair Employment Practices, p. 579.) The same applies for chest X-rays to diagnose tuberculosis and for periodic check-ups.

B. *Community Activities.* Activities against VD, and in the health field generally, should not be confined to the industrial bailiwick. Many of the illnesses of employees which are so costly to industry are not contracted during working hours but off the plant premises.

By joining hands with other community forces having a common interest in promoting better health, industry can make an outstanding contribution to the wartime and all-time campaign against VD and other serious diseases. Such participation on the part of industry is recommended by enlightened self-interest and is in line with current civic-minded policies which add to the prestige of management in the community.

So far, management is represented on the boards of health agencies by individuals who do not speak for their firms. With the formation of active health and safety committees, a basis is established for official company representation on boards and committees of local social hygiene societies and other health and welfare agencies.

A health and safety committee can participate in community activities by passing resolutions, sending representatives to meetings, and working as a group to promote worthwhile endeavors.

Following are some community activities in the fight against VD and in the health field generally which are recommended:

1. *Support Social Hygiene Day*
   National Social Hygiene Day is observed every year early in February in thousands of towns and cities throughout the country. It aims to enlist all community forces—doctors, nurses, churchmen, educators, employees, labor leaders, businessmen, etc.—in concerted action against VD. (Publicity kits on Social Hygiene Day are sent out during November by the American Social Hygiene Association. Ask to be put on its mailing list.)
2. *Support Programs for Youth.*
   Youth centers and other projects aim to save our young people from delinquency.

   Make sex education available to young people. Our youth must be armed and protected with knowledge; in accomplishing this, the home, the school and the church have their vital role to fulfill.
3. *Support Health Departments—*
   For improvement and expansion of VD control facilities, if needed, including provision for free diagnosis and treatment for those who can't pay.

   For adequate appropriations for public health services, local, state and national.
4. *Support for Legislation and Law Enforcement*
   Laws are essential requiring prenatal and premarital examinations for syphilis. If not already passed in your state send for ASHA pamphlet containing typical good laws.

   Enforce laws repressing prostitution, a leading source of venereal infection.

Go To It

The three-point program which has just been offered is a realistic basis for action on the industrial health front. This program is a call and a challenge to the nurse in industry—a call for sincerity and devotion to duty, a challenge to go to it with determination and enthusiasm.

Already on the firing line, the nurse is in a position to stimulate the attack on VD and all other enemy diseases and hazards. Every blow struck now brings victory nearer, and arms us for our postwar mission of rehabilitation and health protection for the people.

Emergency Isolation at Floodtide

By PAULINE L. CRAVEN, R.N.

THE CHILD really was not a "picked bird" but when she was given to our care during the spring floods which occurred in the Wapello County, Iowa, area this year, she did look like one. The sobriquet was given her by the nurse's aides who volunteered to assist us during the flood. She was also one of the patients in the emergency isolation hospital which the public health nurses were asked to establish to help prevent spread of communicable disease. In company with this youngster was a sister who, like the "picked bird," had measles. They came to us after they had spent the night at the office of one of the local physicians in Ottumwa, the county seat.

Inevitably if there is a river flowing through a town, we find the banks dotted with homes of persons like the parents of these children. In times of disaster many of these people, lacking resources, look to the community for assistance. So it was in Ottumwa in May 1944, when the Des Moines River overflowed its banks and engulfed in a torrent the Central Addition, which had been isolated from Ottumwa proper several years ago by the changing of the river channel. A shelter in a vacant store building offered food, warmth, and companionship to 26 adults and 80 children whom it was necessary to evacuate from their homes. It seemed likely that more cases of measles might develop among the children.

To the two county public health nurses the local health officer delegated the task of setting up an isolation unit for the care of communicable diseases which might arise. Immediate arrangements were made to occupy the vacant nurses' home at the county tuberculosis sanatorium.

Eight o'clock the next morning found the public health nurses starting their task of making an isolation unit out of six rooms, a kitchen and a bath, each room having a separate entrance from a central room. The employees of the Sunnyslope Sanatorium had been hard at work already and every room was very clean, each cot and crib made up for occupancy.

The equipment consisted of plenty of linens, soap, hot water, a one-burner electric plate, a utility cabinet, a mop and a broom. Arrangements were made for other supplies needed. The Red Cross supplied the equipment not available at the sanatorium.

Volunteer registered nurses, nurse's aides, persons who had taken the home nursing classes, school nurses, and industrial nurses were solicited for service. All gave freely of their time and efforts. The chairman of the Public Health Nursing Council, herself an authorized Red Cross nurse's aide instructor, and another member of the council, who was also county home nursing chairman, worked side by side with the public health nurses in selecting volunteers and working out a schedule of time. It was arranged that a graduate nurse should be on duty with the volunteer who was assisting.

Each hour of the first day brought a new problem. First there was no telephone, but immediate service was obtained. There was no ice box, but a new garbage can was obtained for this

purpose and 25 pounds of ice daily kept the babies' formula and other foods chilled. Diapers and gowns were obtained at the Red Cross production rooms, all medical supplies needed were approved by the Red Cross.

Meals were the major problem. Dishes, utensils, and staple foods were brought from the sanatorium. A conference with the housekeeper resulted in food being sent to the little hospital at each meal and served by the attending nurse or nurse's aides, thereby resulting in little confusion as all utensils were left at the isolation hospital except when containers were taken to the sanatorium kitchen to be filled with food. Laundry also was taken care of by the sanatorium laundry, except the diapers and gowns which were done by the nurses due to a shortage of these articles and the fact that local facilities were very much rushed.

By afternoon our patients had increased to six in number, a four-year-old brother of our two babies and two small children from another family, all with measles. That evening a little four-year-old colored girl was admitted with chills and fever following her first inoculation for typhoid fever, so she was put in isolation until a diagnosis was made.

A complete examination of each patient was made by one of the local pediatricians. Cod liver oil and Vitamin B proved foremost in the recommended treatment.

As the first week drew to a close and our small hospital was running more smoothly, a new problem confronted us. The three children from the one family were all so undernourished that the physician felt they should not be returned to their parents until their general resistance had been built up with nourishing food and good care. Child Welfare services were obtained and the six-month-old child was placed in a boarding home. Her brother and sister were admitted to the Sunnyslope Sanatorium in the Children's Hospital. The other small children were returned to their homes following an investigation by the public health nurses of the home conditions. The little colored girl was returned to the Red Cross shelter following twenty-four hours of observation in which the only developments were a lot of pep and energy which kept the nurses very busy.

The day before the three remaining children were to be taken to their new temporary homes, one child decided to hatch some eggs, and we had pediculosis. Examinations had been made of each child on entrance and at intervals, but their blond hair had failed to reveal the nits. Treatment prescribed by the physician was carried out under the supervision of the public health nurses. Next morning the condition seemed under control, but the superintendent of the sanatorium felt it safer to shave their heads if they were to be associated intimately with other children. Two small blond heads soon became bald, much to their delight, which was quite different from the usual child reaction.

As the last child was taken away from the isolation unit, the next problem was cleaning, airing and putting our small hospital in readiness for use at any time until this emergency period of the flood had passed and the families had all returned to their homes. For this task, home nursing class graduates volunteered their services. To each was delegated certain tasks and two hours later found everything scrubbed, aired, and a complete inventory of equipment checked.

An SOPHN Backs Legislation

By MRS. WILKES P. COVEY

IT IS PROBABLE that in most states it is suitable and proper for lay interest and participation in public health projects to be informed and directed by the state organization for public health nursing through its members scattered throughout that state. In Minnesota the SOPHN, in the midst of its various professional activities, has always realized that lay knowledge, lay approval, and lay participation are necessary to any public program. The building up of these with the purpose of gaining the friendly attention of the community, is one of the SOPHN's special functions, for no matter how worth while a program is, it is the people behind a program who bring it into actual being and keep it going.

The Minnesota SOPHN has promoted legislation providing for county nursing committees which have worked actively for public health nursing measures through school boards, county commissioners, and whatever other local groups and organizations are suitable in any given region. We have some counties in our state which are relatively well cared for; others, on the other hand, need much more service than is now available. Some of our northern counties, for example, are sparsely settled sections, picturesque with woods and lakes, but unfitted for either agriculture or industry. The medical and nursing services are both inadequate. In 1942, therefore, a bill was introduced into our state legislature for state aid for county nursing which was sponsored by the SOPHN and the State Department of the American Legion. A legislative worker was employed, and lay people interested in public health nursing and representing each legislative district, came in from all over the state to the capital, the SOPHN paying the expenses of some. These women, some of whom had doubtless never done any work of this type before, went right into action. They went into the smoke-filled rooms you hear about, and talked to men who had never heard of public health, explaining the need for county public health nurses.

No nurses did any of the lobbying, so that no one would seem to have a personal axe to grind. Some of the members of the nursing committees were very articulate. They told what the nurses had accomplished in counties where nursing services were already established, and why such services were needed in the others. The committees did a good piece of educational work, and as a result many lay people became interested and the legislators learned of the health needs of their state. The support of other local organizations, such as service organizations and women's clubs was enlisted, and much additional educational work was accomplished.

The bill was first introduced in 1938, and was defeated. However, we had been told that we should not expect success for 10 years or more, especially as the bill called for expenditure of funds, and we continued to have it introduced at each session of the legislature. In 1942 we began to see the results of our educational efforts, for the Finance Committee of the Senate indicated its approval by recommending an appropriation. Unfortunately it was too late for reconsid-

eration by the House Appropriations Committee.

At our coming legislative session, an effort will again be made to secure this legislation. The same general tactics will be used, and we are fortunate in having the same chairman of the legislative committee of the SOPHN, Mrs. C. J. Schmitz. She has on her committee members from each legislative district, and it is among their duties to approach, or to have approached by someone else, their senators and representatives before the session opens, in order that they may be thoroughly informed before the rush of business makes them less accessible.

We are most fortunate in having a new and very valuable source of strength and support. Recently, we were able to interest the Minnesota League of Women Voters in putting on its active list of state projects the backing of public health measures. This includes the bill of which I have just spoken.

This group will also help with another bill which is expected to come up this session and which is a necessary preliminary to the adoption of a country-wide plan for local health units sponsored by the American Public Health Association with the approval of the United States Public Health Service and the American Medical Association. In Minnesota the plan calls for 10 district health units, locally administered, each with its own medical director, sanitary engineer, supervisory public health nurse, one staff nurse to every 5,000 population, and clerical staff. Its purpose is to streamline the hundreds of local setups of cities, townships, and counties into well staffed, well integrated units. There is at present no law allowing counties to combine funds for any such purpose, so the first step necessary in any state is to pass an enabling act, permitting such action. It is this enabling act, which we hope will come up in Minnesota this session.

To spread a knowledge of this project, the chairman of the lay members section of the Minnesota Organization for Public Health Nursing arranged a meeting last May with Dr. Haven Emerson, chairman of the Committee on Local Health Units of the American Public Health Association, and at the present time a guest professor of public health at the University of Minnesota, as speaker. Dr. Emerson presented details of the plan to a group of about 50 representatives of all sorts of organizations from all over the state. Among them was a member of the program committee of the League of Women Voters who a few weeks later was influential in putting the backing of public health measures on the League's active state list.

Probably the most effective way to promote interest and membership in an organization is for it to take active part in a worth-while program in which lay people can participate. We understand that Nebraska and North Dakota are among states which have already passed an enabling act, and any of our state organizations interested in this particular project could probably get help from them. Information might be obtained as to the text of the act and the methods which were used both before and after its passage.

Presented at Council of Branches Open Discussion Meeting, Biennial Convention, Buffalo, New York, June 7, 1944, on Present and Future Needs in Public Health Nursing.

WITH THE return of service men to civilian life, one question regarding the EMIC program comes up with increasing frequency," states Katharine F. Lenroot, chief of the U. S. Children's Bureau. "It has to do with the eligibility of the wife or infant after the husband or father has left the service. If the application was approved and care was authorized while the service man was in one of the eligible pay grades, it is continued for the period of authorization even after his discharge." Care is given on a similar basis to wives and infants of those who are prisoners of war, missing in action or deceased.

Reviews and Book Notes

MATERNAL OVERPROTECTION
By David M. Levy, M.D. 417 pp. Columbia University Press, New York, 1943. $4.50.

This intensive study of 20 cases showing "pure" maternal overprotection is the result of many years of painstaking effort on the part of author and collaborators. Pure maternal overprotection is characterized by (1) excessive contact—the inseparability of mother and child (2) infantilization—the mother's concern over feeding, dressing, bathing, washing, punishing, and other aspects of the child's behavior typical for children of younger years (3) prevention of independent behavior—referring to the "active prevention" of the child's growth "in the direction of self-reliance" (4) lack or excess of maternal control derived primarily from the behavior of the child, indicating a defect in maternal discipline.

In the clinical manifestations of overprotection, mothers of dominating children are indulgent and mothers of submissive children are dominating. Children who were "wanted" showed a slightly greater preponderance in the entire feeding group than children who were "unwanted." The overprotecting mothers breast fed their children longer than mothers in other groups. Within the home, activity hindering the growth of more responsible behavior was largely limited to the matter of chores and school work. Formation of friendships may be combated throughout childhood. When the child's interests extend beyond the family circle, the mother reaches out in every direction to protect him and prevent anything that will jeopardize her monopoly. Thoroughgoing psychological studies made on these children showed their "superior educational achievement, relatively high scores in language, poor scores in arithmetic, and special interest in reading." The mothers' response to the school situation was frequently revealed in a negative attitude toward teachers and interference with classroom activities of the children as well as continual coaching at home. Eleven of the 20 children studied reacted to the mothers' attempts to control their behavior by defiance and rebellion. Most of these mothers had tolerated this type of behavior a number of years before asking for help.

Eleven mothers had experienced one or more instances of relative sterility prior to birth of the child being studied. In commenting on the psychopathology present, the author states that "maternal overprotection resembles obsessional neurosis more than any other . . . this resemblance also would lend support to the theory that maternal overprotection represents a type of neurosis in which especially processes of guilt result in exaggerated maternal care." The study reveals that these mothers have made the child their exclusive social life and comment is made that sexual compatibility and social interests in common between the husband and wife mitigate against development of maternal overprotection.

These children got along very well in school. Even those whose behavior at home was characterized by aggression, hostility, and disobedience were not problems in the classroom.

Feeding problems occurred in 12 of the 20 cases. Bowel and bladder control were established normally and without untoward incident in all but two of the cases. This group of children was taller

and heavier than comparable groups, testifying, perhaps, to the rigid adherence of the mother to health routines.

It was found that attempts to give the mothers insight into the dynamics of their overprotective attitude were unsuccessful. Manipulation of the environment proved to be the most successful method of management. Fathers were encouraged to develop a better relationship with their wives, thereby releasing the child from the mother's domination. Children were separated from their mothers for varying lengths of time by being sent to camps and to boarding schools. The mothers reacted on the whole favorably to educational therapy when they were encouraged to try new techniques in handling the child and little reference was made to the reason why these techniques should be tried or previous methods had failed. Psychotherapy with the patients was uniformly unsuccessful. The children never recognized that they had problems.

These cases have been carefully checked over a period of years and accurate follow-up studies are included. This is one of the most thorough attempts that has been made to study the various aspects of a mother-child relationship. The book is not only of inestimable value to workers in the child guidance field but it could be profitably used by pediatricians, nurses, and teachers as well. Dr. Levy does not pretend to give us any "last words" on this subject but leaves it open for further research and investigation.

MILTON E. KIRKPATRICK, M.D.
New Orleans, La.

THE WAR AND MENTAL HEALTH IN ENGLAND

By James M. Mackintosh, M.D. 91 pp. The Commonwealth Fund, New York, 1944. 85 cents.

With the simplicity, skill, and art of a great teacher, these short essays share with the reader some of a well-known psychiatrist's philosophy as "lantern slides in a rough time sequence." This is a small book and will be found satisfying refreshment for an evening's reading—or interrupted hours—such is the style of presentation.

The tremendous impact of war on the young soldier, the housewife, the child, the hospital patient, and the student is presented with keen understanding of their reactions and behavior as well as of those responsible for planning for their well-being. The chapter, End of the Beginning, brings mobilization for peace, or as we here more frequently say, postwar planning, to major focus. The discussions of services of hospitals, voluntary organizations for mental health and professional education, as well as some of the problems of the future and principles to follow in meeting them are, while applied to England, equally pertinent for us.

You will feel better for having read this book, will look forward to re-reading many parts of it, and, of more importance, will make use of it. We, too, appreciate that education must be given great prominence in postwar programs and that "the capacity for enjoying work and making good use of leisure—the capacity for living the good life—can come only from within, and the only true begetter is education."

CAROLINE E. FALLS, R.N.
New York, N.Y.

OCCUPATIONAL THERAPY IN THE TREATMENT OF THE TUBERCULOUS PATIENT

By Holland Hudson and Marjorie Fish, O.T.R. 317 pp. National Tuberculosis Association, 1790 Broadway, New York, 1944. $3. May be purchased through your state or national headquarters.

As the authors state, this book is meant primarily as a text for undergraduate students of occupational therapy. The first part is a simple word picture of the cause and treatment of tuberculosis. However, public health nurses, especially our new war emergency nurses, may profit by a review of chapters 4 through 8, which take up diagnostic aids, the modern tuberculosis hospital, length of stay, and social stigma.

Part II should be of definite value to the public health nurse in aiding her to prepare her patients for hospitalization. In reading this part of the book one has a feeling of being a part of the hospital. The various reactions of the patients are anticipated; one walks in the corridors, sits by the bedside, sees, lives, thinks, and feels with the patients. Part III is of little specific value to the public health nurse, as it is a description of occupational therapy services. Part IV, Planning and Growth, takes the patient back into the community and has to do with his rehabilitation. Rehabilitation has long been neglected but is being increasingly emphasized.

The book is well and simply written. Its contents can be easily and quickly absorbed, which is important to the public health nurse who has too little time for professional reading.

RUBY RIPPERTON, R.N.
Austin, Tex.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

HEALTH EDUCATION

HEALTH INSTRUCTION YEARBOOK, 1943. Compiled by Oliver E. Byrd, Ed.D. Stanford University Press, Stanford University, California, 1943. 308 pp. $3.

This volume is the first in what seems to be a useful series of yearbooks. Dr. Byrd selects from many journals each month articles that deal with current developments in the field of health education. Summaries are arranged in a convenient topical form with complete sources so that easy reference can be made to the complete article. In spite of the fact that the selection represents the judgment of one person the volume offers a rapid method of surveying recent developments in experience, thought, and research in the broad field of health.

PRACTICAL TEACHER HEALTH EDUCATION: CONCRETE SUGGESTIONS FOR GIVING TEACHERS-IN-TRAINING EXPERIENCE AND THE OPPORTUNITY TO "LEARN BY DOING" IN COMMUNITY HEALTH FIELD WORK. By Ruth E. Grout, Ph.D. *Bulletin of the National Tuberculosis Association*, National Tuberculosis Association, 1790 Broadway, New York 19, N.Y., May 1944. p. 271. Free.

GENERAL

VOCATIONAL REHABILITATION. Sarah Allen Beard. Occupational Abstract No. 71. Occupational Index, Inc., New York University, Washington Square, New York 3, March 1944. 5 pp. Single copies, 25 cents; annual subscription to Occupational Abstracts, $2.50.

Information on vocational rehabilitation as a career.

POSTWAR PLANNING IN THE UNITED STATES: AN ORGANIZATION DIRECTORY. The Twentieth Century Fund, 330 West 42 Street, New York 18, 1944. 151 pp. $1; special quantity rates.

This is the third in a series of directories briefly describing organizations engaged in research or education of general public interest in the field of postwar problems, and the work they are doing.

PROCEEDINGS OF THE SECOND NATIONAL WARTIME CONFERENCE OF THE NATIONAL COUNCIL OF SCIENTIFIC, PROFESSIONAL, ART, AND WHITE COLLAR ORGANIZATIONS, JUNE 2ND AND 3RD, 1944, NEW YORK CITY. National Council of Scientific, Professional, Art, and White Collar Organizations, 135 East 52 Street, New York 22, 1944. 52 pp. Single copies 25 cents postpaid; 10 copies $2.20 plus postage.

TUBERCULOSIS

THREE YEARS' EXPERIENCE IN THE UPPER HARLEM CHEST CLINIC. Jean Downes and Neville C. Whiteman. Reprinted from *The Milbank Memorial Fund Quarterly*, April 1944. Milbank Memorial Fund, 40 Wall Street, New York. 13 pp. Free.

An excellent guide to the public health nurse in follow up of the patients and their families.

MENTAL HYGIENE

A PSYCHIATRIC CONSULTATION SERVICE IN A PEDIATRIC OUTPATIENT DEPARTMENT. Mabel Huschka, M.D. Reprinted from *The Journal of Pediatrics*, St. Louis, February 1944. 16 pp.

MENTAL HYGIENE IN THE CHILD HEALTH CONFERENCE. Martha W. MacDonald, M.D. *The Child*, August 1944. U. S. Department of Labor, Children's Bureau. pp. 27-30. Reprints available free from the Children's Bureau, Washington 25, D.C.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HELENE BUKER, NEW MEMBERSHIP CHAIRMAN

NOPHN announces with pleasure that its newly organized Membership Committee for the 1944-46 biennium will act under the leadership of Helene B. Buker, director, Bureau of Public Health Nursing, Michigan State Department of Health. Miss Buker is a graduate of Colby College and of the famous Vassar Training Camp of World War I. She was formerly public health nurse in Walpole, Massachusetts; staff nurse, assistant supervisor and supervisor, Visiting Nurse Service of New York; and director of public health nursing, Cattaraugus County Health Department.

Almost each year sees a steady gain in NOPHN membership among public health nurses, board and committee members and other friends of public health nursing. A large share of responsibility and credit for the increase in National memberships goes to the hardworking nationwide committee composed of representatives in every state and territory. The present state membership representatives, who are listed below, were honored and the new members introduced at a tea given by the NOPHN early in October during the APHA annual meeting in New York. Additional members of the committee are expected to be announced soon.

STATE MEMBERSHIP REPRESENTATIVES*

ALABAMA—Mamie L. Griffin
ALASKA—Margaret E. Higgins
ARIZONA—Mrs. Edna Marx
ARKANSAS—Mrs. Ann Presley
CALIFORNIA—Mrs. George Aubin (until 1945), Mrs. Sumner Spaulding (Southern California)
COLORADO—Louise Zetsche, Mrs. Robert G. Bosworth
CONNECTICUT—Helen M. Giles, Mrs. Louis L. Coudert
DELAWARE—Hazel I. Lycan
DISTRICT OF COLUMBIA—Mildred Negus
GEORGIA—Jewell Page, Mrs. J. Randolph Tobias
HAWAII—Virginia A. Jones
IDAHO—Lillian O'Callaghan, Mrs. R. S. Stringfellow
ILLINOIS—Mrs. Eloise T. Phelps (Chicago), Janet Jennings
INDIANA—Margaret Torr
IOWA—Margaret Maxwell, Elizabeth Trei
KANSAS—Mary McAuliffe, Isabel Noble
LOUISIANA—Marie C. Quigley
MAINE—Helen F. Dunn, Mrs. Langdon T. Thaxter
MARYLAND—Miriam Ames
MASSACHUSETTS—Mary Macdonald, Mrs. Sheridan R. Cate (Western Massachusetts)
MICHIGAN—Marion I. Murphy, Mrs. James K. Watkins
MINNESOTA—Evelyn Nelson, Mrs. Wilkes P. Covey
MISSISSIPPI—Mrs. Syd V. Schneidau
MISSOURI—Margaret Willhoit, Mrs. John A. Haskell
MONTANA—Sarah Barnes, Nora Harber
NEBRASKA—Mrs. Nelda D. Belknap, Mrs. Herman F. Johnson
NEVADA—Della Fitzgerald
NEW HAMPSHIRE—Mrs. Mary D. Davis
NEW JERSEY—Gertrude L. McLaughlin, Mrs. S. Emlen Stokes
NEW MEXICO—Victoria Mayer
NEW YORK—Mrs. Anna V. Matz (New York City), Mrs. John M. Satterfield (Northern New York State)
NORTH CAROLINA—Mabel A. Patton
NORTH DAKOTA—Irene M. Donovan
OHIO—Anne R. Falther, Mrs. R. Livingston Ireland
OKLAHOMA—Catherine Siggins
OREGON—Ethel Mealey, Mrs. Saidie Orr Dunbar
PENNSYLVANIA—Catherine Sheckler, E. Jeannette Morse
PUERTO RICO—Pauline R. Davila (Nurse Representative), Celia Guzman (Nurse Representative)

*Name of person listed first is nurse membership representative; person listed second is general membership representative; unless otherwise stated single name is nurse representative.

RHODE ISLAND—Elizabeth Reynolds, Mrs. William L. Marchant
SOUTH CAROLINA—Mrs. Minnie H. Blease, Mrs. Eunice H. Leonard
SOUTH DAKOTA—Alice B. Olson
TENNESSEE—Lucile Satterfield, Mrs. Arch Trawick
TEXAS—Ruth Albrecht
UTAH—Mrs. Hattie Solomon
VERMONT—Ruby A. McKewen
VIRGINIA—Sarah Radcliffe
WASHINGTON—Laura G. Gibson, Mrs. Dietrick Schmitz
WEST VIRGINIA—Cecilia Robrecht
WISCONSIN—Ione M. Rowley
WYOMING—Frances M. Hersey

NOPHN EXECUTIVE COMMITTEE MEETS

The new Executive Committee of the NOPHN Board of Directors had countrywide representation and almost 100 percent attendance at its first meeting on October 6 in New York. Many problems related to the postwar emphases of the National were discussed, and the financial status of the Organization, which was reported to be satisfactory, was considered in relation to a number of new and interesting projects.

Marion W. Sheahan, newly-elected president, presided at the meeting for the first time. Other officers present were: Emilie G. Sargent—1st vice-president; W. Lawrence McLane—treasurer; and Ruth Houlton—secretary.

New members of the Committee who attended were: Gladyce L. Badger, director, Nursing Service, American Red Cross, Pacific Area and Dr. Jessie M. Bierman, chief, Division of Maternal and Child Health, State Department of Public Health, both of San Francisco, California; Mrs. Walter Lippmann, national director, Volunteer Nurse's Aide Corps, American Red Cross, Washington, D. C.; Ella E. McNeil, associate professor, public health nursing, University of Michigan, Ann Arbor; Dr. Joseph W. Mountin, medical director, Chief, States Relations Division, USPHS; Rose Schneiderman, president, Women's Trade Union League, New York, N. Y.; Julia Dupuy Smith, director, Instructive Visiting Nurse Association, Richmond, Virginia; and Mrs. Langdon T. Thaxter, vice-president, Portland Community and War Chest, Portland, Maine.

Three NOPHN section chairmen were present— Alfhild Axelson, representing the School Nursing group; Anna M. Fillmore, the Industrial Nursing Section; and Helen L. Fisk, first chairman of the new Nurse-Midwife Section.

WATCH FOR *Phn*, NOVEMBER!

January 26 is "Public Health Nursing Day," a time when attention will be called to public health nursing as a vital community service. Publicity programs, through the media of the radio, the press, exhibits and meetings, will be planned by nursing and other health agencies to give the Nation a better understanding of public health nursing. Your next *Phn*, November issue, will be devoted exclusively to plans for the Day, bringing you many concrete suggestions and publicity aids. *Watch for it.*

NURSE-MIDWIFE SECTION GETS UNDERWAY

Helen L. Fisk, state advisory nurse, Division of Public Health Nursing, Baltimore, Maryland, and Hattie Hemschemeyer, assistant director, Maternity Center Association, New York City, are the chairman and vice-chairman of the newly formed Nurse-Midwife Section of the NOPHN which held its initial meeting early in October.

Three committees concerned with the completion of the organization of the Section will submit reports at an early date. They are: Nominating Committee, Ruth Doran, chairman; Committee on Constitution and Bylaws, Ethel Turner, chairman; Program Committee, Lalla Mary Goggans, chairman. In drawing up a slate for membership of the Executive Committee of the Section, representation will include the following: a university, the various schools of nurse-midwifery, an obstetrician, a health officer, a staff nurse giving direct service, a nurse-midwife working in a hospital; also the Children's Bureau, USPHS, NOPHN will be represented.

The section has as its purpose clarification and interpretation to public health administrators and other co-workers the position, functions and qualification requirements of nurse-midwives in public health agencies.

COLLEGIATE COUNCIL AND FIELD REPRESENTATIVES

Twenty-seven of 30 colleges and universities offering approved public health nursing programs of study were represented at the meeting of the Collegiate Council on Public Health

Nursing Education October 2 in New York. The business of the morning session was conducted through four discussion groups on advanced programs of study in tuberculosis nursing, industrial nursing, mental hygiene and supervision. These were led by Collegiate Council members with the assistance of nursing specialists, including those from the U. S. Public Health Service and the Children's Bureau. Representatives from the field agencies—46 from the 173 agencies which offered field experience to public health nursing students during 1943-44—attended the afternoon session which was devoted to a discussion of student field experience programs.

An analysis of the 173 agencies located in 26 states reveals the following: 14 are city health departments; 112, county health departments; 26, visiting nurse associations; 8, other private; 8, boards of education; 2, teaching centers; 3, joint services.

Newly-elected officers of the Council are: chairman—Ruth Freeman, University of Minnesota; vice-chairman—Dorothy Rood, University of Pittsburgh; secretary—Mary C. Connor, NOPHN education consultant.

MEETS WITH SECTION

Ruth Scott, new NOPHN industrial consultant, met with the Executive Committee of the NOPHN Industrial Nursing Section for the first time at the Section's annual luncheon meeting in New York, October 3. Ten members of the Section, which is unusually good representation for the group, were present.

NEW YORK MEMBERSHIP MEETING A SUCCESS

A record attendance of over 2,000 persons from the surrounding area of metropolitan New York, New Jersey, and Connecticut contributed to the success of a lively meeting of the New York City Membership Committee of the NOPHN held the evening of October 2 preceding the APHA annual conference. Mrs. Anna V. Matz, of the New York City Department of Health and chairman of the Committee, presided over the meeting and introduced the speakers and 20 special guests of the evening. Cadet nurses of the Kings County Hospital Glee Club entertained with songs.

The speakers and their respective topics were: Dr. C.-E. A. Winslow, "Has Public Health Nursing Reached Its Destination?"; Marion W. Sheahan, "Educational Opportunities in Public Health Nursing"; Alma C. Haupt, "National Unity in Public Health Nursing." Much of the material offered at the meeting will appear in future issues of the Magazine.

Program committee for the occasion was: Alice M. Donahue, chairman; Hertha E. Larsen; Borie Toth; and Theresa Grausbord. Other members of the New York City Membership Committee are: Ellen Black, Esther Brady, Dorothy Carroll, Mrs. Elisabeth H. Emery, Mrs. Eleanor C. Ford, Gladys L. French, Sarah Ward Gould, Ruth H. Schramm, Mary M. Sullivan.

NOPHN BUSINESS OFFICE BEING REORGANIZED

Reorganization of business procedures and policies in process at the National office has resulted to date in increased efficiency and concrete savings to the organization.

A new membership filing system eliminates duplicate files at an estimated yearly savings of $2,000. New controls in the Bookkeeping Department assure daily deposit of incoming money and lessen the detail of work. Lines of authority and definition of responsibilities have become clear-cut and defined for the Addressograph Room, Stockroom, Membership and Ordering Departments.

A review of personnel policies has resulted in salary adjustments for the staff, the establishment of salary ranges and the clearing away of vacations and overtime long overdue. The favorable effect of the changes initiated in both policies and procedures is evidenced also in a more satisfied staff which shows a turnover thus far in 1944 of 2½ percent (only one resignation and that due to pregnancy) as compared with percentages of 22, 35, 30, and 24 in 1943, and 1942, 1941 and 1940 respectively.

NOPHN ON NATIONAL URBAN LEAGUE COMMITTEE

NOPHN has appointed Ruth Fisher, assistant director and director of the Organization's AWCS project, as its representative on the Community Relations Project Advisory Committee of the National Urban League.

This project in interracial social planning is aimed at developing and testing techniques to be applied to relieve the constantly increasing racial tensions in war industry centers brought

(Continued on page A9)

NEWS AND VIEWS

Highlights on Wartime Nursing

NURSES BALANCE 1946 SUPPLY AGAINST NEEDS

A national shortage of 111,340 registered professional nurses by July 1, 1946, that must be filled by students, aides, and practical or vocational nurses, is foreseen in estimates of nursing needs and resources, just reported to the National Nursing Council for War Service by its Committee to Estimate Nursing Needs for Wartime. Chairman of the Committee is Pearl McIver, chief, Office of Public Health Nursing, U. S. Public Health Service.

Based on wartime conditions, the figures allow enough additions and replacements to bring the Army and Navy Nurse Corps to their present combined ceiling of 60,500 and keep them there.

"If, happily, military requirements have been reduced by 1946," said Miss McIver, "our overall estimate will still be conservative, we believe. Civilian as well as military needs have been figured on a wartime basis. The war has curtailed home front services severely. Hospitals are still closing some wards because it is utterly impossible to get nursing personnel. If the Army and Navy release any nurses during the next year and a half, they will be absorbed quickly in bringing civilian services back to normal."

The report is a first major step in gathering information for the National Nursing Planning Committee, which is launching its work under the chairmanship of Marion W. Sheahan, president of the National Organization for Public Health Nursing, (see also PUBLIC HEALTH NURSING, October 1944, p. 497).

Miss Sheahan said that the national figures may need to be modified from time to time as new specifications are secured from state and local groups about needs and resources in particular areas.

"As they stand, however, they will help give direction to the National Nursing Planning Committee which was set up to implement the purpose of the nursing profession. That purpose is to provide and maintain nursing services at a high level of competence to meet the needs of all the people.

"We recognize that health needs of all the people have not been adequately met in the past. The high percentage of draft rejections is a clear indication. One of the tasks our committee faces is to explore the possibilities of distributing nursing services better through a more equitable distribution of costs. That is, nursing services must be distributed more nearly according to need, rather than ability to pay."

Miss Sheahan pointed out that 111,340 fewer nurses than jobs does not mean patients will be left without care.

"We have always depended heavily upon our student body for nursing services and they will continue to help fill the gap. However, as more technical knowledge is demanded of them, we must reduce the practice hours required of them to a minimum necessary to acquire nursing skills.

"The American Medical Association Hospital census for 1943 listed 17,309 vocational or practical nurses. Doubtless more of these vocationally trained workers will be employed by hospitals and health services, particularly as the ranks of volunteer nurse's aides thin with the coming of peace. We hope, however, that the yeoman service rendered by the volunteer Red Cross nurse's aides will continue as long as it is needed."

Providing supplementary nursing services is not the whole answer, according to Miss Sheahan. In the light of past experience, about 35,000 nurses can be expected to withdraw from active practice in the next year and a half, she pointed out.

"Some nurses leave the profession for unavoidable reasons such as ill health, or to become wives and mothers," she said. "Others leave it for better pay or more agreeable working conditions. Our committee believes that one of the soundest ways to assure adequate

nursing services to meet the needs of the people is—to quote our 10-point action program—'to promote, develop, and adopt personnel policies and practices which will be satisfactory to employer and employees, and which provide remuneration for nurses commensurate with the services they render to society.'"

The estimates set graduate nurses available by July 1, 1946 at 304,344 as compared with needs for 415,684 nurses. No allowance was made for vacations and sick leaves for nurses in computing the totals.

The report takes account of the growing trend toward hospital care for the sick by reducing the 60,499 nurses who were in private practice on July 1, 1944 to an estimated 55,000 active by July 1, 1946. Industrial nurses are increased from 13,805 to 16,874. The increase in nurses in non-military federal employment from 6,820 to 8,288 is to fill positions authorized for the fiscal year 1945.

The greatest percentage of increase is indicated in the public health field where the 20,731 now employed by non-federal agencies is advanced to 29,699. The larger figure is based on the minimum of one staff nurse for 5,000 population and a supervisor or consultant for every nine staff nurses. A number of states offer services above this minimum. One New England state, for example, has one public health nurse for every 3,400 people. On the other hand, a state in the Southwest has only one public health nurse for every 18,000 population.

"The war years have taught us much about community cooperation on health problems," said Miss Sheahan. "Our nursing councils for war service have the help of hospital executives, physicians, public health authorities, and the general public in making nursing skills contribute their utmost toward the well-being of the people. We urge that this cooperation continue and grow in years of peace as well as in war."

Report to
THE NATIONAL NURSING COUNCIL FOR WAR SERVICE
From its Committee to Estimate Nursing Needs in Wartime
Accepted by Council, September 15, 1944

NURSES AVAILABLE BY JUNE 30, 1946

Nurses in Army and Navy Nurse Corps January 1944		43,164[1]
Nurses active January 1, 1944 (civilian)	221,948[2]	
Withdrawals by June 30, 1946 (civilian)	31,231[3]	
Remaining active June 30, 1946 (civilian)		190,717
Students graduated January 1944 to June 1946	74,588[4]	
Withdrawals of new graduates by June 1946	4,125[5]	
New graduates remaining active June 1946		70,463
Total graduate nurses available June 30, 1946		304,344
Nurses needed by June 30, 1946		415,684[6]
Total graduate nurses available by June 30, 1946		304,344
Graduate nurse shortage (to be made up by service of students and practical nurses)		111,340

[1] Attrition and increases 1944-1946 were not calculated on this group since provision for attrition and increases in Army and Navy Nurse Corps was made in establishing 1946 needs

[2] Estimate of P & A

[3] Withdrawals at rate of 6 percent per year for 2½ years

[4] Estimated by National League of Nursing Education

[5] Withdrawals at rate of 6 percent for portion of period during which they were graduate nurses

[6] This figure assumes all nurses work 52 weeks per year. No allowance for vacations or sick leaves have been made

ESTIMATED NURSING NEEDS FOR WARTIME

Military	*July 1, 1944*[1]	*July 1, 1946*
Army	40,018	50,000
Navy	8,399	10,500
		60,500
Replacements for Army at 200 per month (24 months)		4,800
Replacements for Navy at 100 per month (24 months)		2,400
Total Military Nursing Needs	48,417	67,700
Non-Military Federal	*July 1, 1944*[1]	*July 1, 1946*
Public Health Service	1,360	1,608[2]
Veterans Administration	3,920	5,799
Office of Indian Affairs	569	769[2]
Other Federal Agencies	971	1,112[2]
Total Non-Military Nursing Needs	6,820	9,288
Total Federal Nursing Needs	55,237	76,988
Non-Federal	*July 1, 1944*	*July 1, 1946*
General and Special Hospitals	180,919[3]	188,227[10]
Institutions (Convalescent and Other)	3,077	3,077
Mental Hospitals	21,228[4]	21,930[11]
Tuberculosis Hospitals	7,601[5]	7,601
Private Duty	60,499[6]	55,000[12]
Public Health	20,731[7]	29,699[13]
Industrial	13,805[8]	16,874[14]
Anesthetists	3,609[9]	3,965[15]
Other	18,476[6]	12,323[16]
Total Non-Federal Nursing Needs	329,945	338,696
Grand Total	385,182	415,684

[1] "Facts About Nursing for 1944"—Nursing Information Bureau, 1790 Broadway, New York City.

[2] Authorized positions for fiscal year 1945.

[3] Estimated on basis of daily average number of patients as reported by Journal of American Medical Association, March 25, 1944, and the wartime standards approved by the Procurement and Assignment Service, War Manpower Commission. Since Procurement and Assignment Service standards include service rendered by practical nurses, the 28,000 practical nurses now employed by non-federal general and special hospitals have been subtracted from this total. No provision has been made for vacations and sick leave.

[4] Estimated on basis of daily average number of patients in non-federal mental hospitals as reported by the American Medical Association and standards for graduate nurse service recommended by the National Mental Hygiene Society.

[5] Estimated on daily average number of patients in non-federal tuberculosis sanatoria as reported by the American Medical Association and standards recommended by the National Tuberculosis Association.

[6] Facts About Nursing for 1944, p. 52, reported 54,287 active private duty nurses in 38 states in June 1944. If same ratio of private duty nurses to population were active in remaining states, total would have been 60,499.

[7] Annual Census of Public Health Nurses, U. S. Public Health Service, 1944.

[8] Annual Census of Public Health Nurses, U. S. Public Health Service, 1944, and supplemental figures supplied by Industrial Hygiene Division of Public Health Service for certain States.

[9] 1944 "Hospital Issue" of the Journal of the American Medical Association.

(Footnotes are continued at the bottom of page 598)

ESTELLE M. RIDDLE SCHOLARSHIP ESTABLISHED

A scholarship in the name of Estelle Massey Riddle for a 5-year nursing course leading to the B.S. degree in the joint program of Fisk University and Meharry Medical College has been donated by Mary Porter Scott, chairman of the Municipal Nurses Board, St. Louis.

Providing tuition and fees of $200 a year for the next four years, the scholarship will be awarded when possible to a St. Louis girl.

Miss Scott gave the scholarship in recognition of Mrs. Riddle's contribution to the Homer G. Phillips School of Nursing of which she was director from 1940 to 1942. She is now consultant in Negro nursing for the National Nursing Council for War Service.

Of Mrs. Riddle, Miss Scott said, "By word and example, she developed self-reliance, initiative and a sense of responsibility in her students. She never missed an opportunity to interpret her work and aims to the community and through all the trials and difficulties of reorganization she retained her tolerance and fine sense of humor."

An article, "What Price 'Quotas'!" by Mrs. Riddle appeared in the August 1944 PUBLIC HEALTH NURSING.

MEN NURSES NEEDED

The National Nursing Council for War Service sees a growing need for more well-prepared men nurses and is urging its state and local councils to recruit men, especially veterans, for approved schools offering training facilities.

Selective Service and an abundance of war jobs account for a present shortage of men student nurses. The urgent need for them lies particularly in the fields of psychiatric and genito-urinary nursing, according to Dr. Edward A. Strecker, former president, American Psychiatric Association, and Dr. Thomas Parran, Surgeon General, USPHS, in recent communications to the Council.

Suggestions for action by state and local councils include: giving information to vocational counselors and high school principals on opportunities, especially in areas where there are training facilities; conferring with Selective Service on deferment of essential men nurses including eligible 4-F's and with U. S. Employment Service on guidance of potential students, including eligible 4-F's and discharged veterans.

ALPHA PHI SCHOLARSHIPS AWARDED

Five women students enrolled in collegiate nursing programs this year at Syracuse University, Duquesne University, Russell Sage College, the University of Washington and Dillard University are receiving sums of $200 or more each—$1,200 in all—from the War Nursing Fund of Alpha Phi International Fraternity. The scholarships, which are administered through the NNCWS, were established to aid promising students during the period of their collegiate programs not covered by federal scholarships.

APHA PUBLIC HEALTH NURSING SECTION

New officers of the Public Health Nursing Section of the American Public Health Association for the coming year are:

Chairman—Helene B. Buker

Vice-chairman—Mary C. Connor

Secretary—Rosalie Peterson

Marion H. Douglas replaces Olive Whitlock Klump on the Section's council which is composed of five members serving five years.

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[10] The daily patient average in non-federal general hospitals increased 2.2 per cent in 1943 over 1942. A similar increase was assumed for the years 1944 and 1945.

[11] The daily patient average in mental institutions increased 1.6 per cent in 1943 over 1942. A similar increase was assumed for 1944 and 1945.

[12] 5,500 less than were reported active by the registries in June 1944.

[13] Number needed to meet minimum of 1 staff nurse per 5,000 population and 1 supervisor or consultant per 9 staff nurses.

[14] Rate of increase in 1944 over 1943 was 23 per cent. One half that rate of incease was estimated for the years 1945 and 1946.

[15] Same rate of increase as increase in 1943 over 1942 as reported by the American Medical Association.

[16] Since 6,809 of the 18,476 who were classified as "other" in 1943 were unmarried and under 45, the 1946 estimate was reduced by 33⅓ percent. It is assumed this 33⅓ percent entered the armed forces.

From Far and Near

● Marion Ferguson, public health nursing consultant, USPHS, District No. 3, Chicago, Illinois, has received her Ph.D. degree in educational research in public health nursing administration from Columbia University, New York, the first such degree in public health nursing so far as the NOPHN can determine. About 10 other public health nurses have doctor's degrees, but they are in the fields of sociology, child development, psychology and education.

Miss Ferguson's thesis, "Service Load of a Staff Nurse in One Official Health Agency," is the result of study of records of 600 patients compiled from 2,800 clinic, field and office visits made by nurses of the Bureau of Public Health Nursing, District of Columbia, and the analysis of time data to determine the service load. The thesis will be available in printed form in January 1945 and the NOPHN and the National Health Library hope to have copies available for study and loan. See also Miss Ferguson's article "What Do We Do with Our Nursing Time?", March 1941 PUBLIC HEALTH NURSING.

● Annual meeting of the National Committee for Mental Hygiene will be held November 8-9 at the Hotel Pennsylvania, New York City. Topics for the various sessions will include: "Mental Hygiene of Industry and Reconversion"; "Rehabilitation and the Returning Veteran"; "Race Relations"; and "Services to the Mentally Ill Today."

● Mabel Mortvedt and Florence Bouton have joined the staff of the Nursing Section, Procurement and Assignment Service, War Manpower Commission, as field consultants. Miss Mortvedt will have headquarters in Washington, D. C.; Miss Bouton in San Francisco, California.

O'Connor and Dublin to Red Cross—The recent appointment of Basil O'Connor as chairman of the American Red Cross Central Committee and Dr. Louis I. Dublin as his assistant is welcome news to public health nurses.

Both Mr. O'Connor, as head of The National Foundation for Infantile Paralysis through whose grant the NOPHN has maintained its orthopedic department, and Dr. Dublin, through his long-time association with public health nursing services in the MLI and elsewhere, have an excellent background of experience and detailed knowledge of public health nursing service.

Dr. Dublin will act as coordinator of the various operating divisions of the Red Cross and serve as liaison official between the chairman and vice-chairman. One of the problems for eventual consideration of the Central Committee will be that of transferring Red Cross wartime emergency nursing services to existing official and voluntary agencies in peacetime.

Health Goals of the Future—Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, listed for September *Briefs*, (Maternity Center Association) nine phases of public health in which notable progress can be made with the concerted effort of all concerned —doctors, community leaders, public health workers, teachers, ministers. These are:

1. The complete elimination of tuberculosis, not only as a problem of mortality, but more important, of morbidity. . . . This calls for more serious attack on the rehabilitation of the tuberculous so that the huge sums spent on sanatorium care will not be wasted.

2. A further reduction of maternal and infant mortality—perhaps by one half. . . . The problem of more and better facilities is particularly pressing in the rural areas and among Negroes.

3. An increasing effort to combat a host of conditions which do not by themselves involve a heavy mortality but which are a constant drain and pave the way for more serious diseases. . . . Among these diseases are the common cold and the upper respiratory infections, and their control will probably come through a concerted attack on the virus diseases which are only beginning to be investigated.

4. More concern with the mental diseases which constitute a major social and medical problem. . . . We must explore the causes which bring about mental breakdown, Dr. Dublin points out, and learn how to prevent and to cure it.

5. Cleaning up the venereal diseases which account for a shockingly high toll of disability. . . . There is no good reason why the United States cannot accomplish what Sweden has done.

6. More intensive study of the degenerative diseases of later life. . . . With more knowledge of the physiological effect of the hormones and of methods of synthesizing them, we should have powerful aids at our command to maintain healthier and more vigorous bodies.

7. Concentration of more effort in the control of cancer.

8. More emphasis on nutrition. Wider application of the recent discoveries in this field will

open new avenues for increased vitality and health. In the field of maternity alone, if expectant mothers could be taught the importance of a sound, balanced diet, the lives of thousands of babies could be saved.

9. Public health and the war. The war has focused attention on a number of health problems—tropical diseases and preventing their spread, rehabilitation of the tuberculous, the wounded, and psychiatric veterans.

Report on Insulin Shock Therapy—Use of "insulin shock therapy" in the treatment of dementia praecox patients has resulted so favorably, both to the individual and in substantial savings to the state, that extension of the therapy to all such patients in New York State hospitals for the mentally ill has been recommended by the Temporary Commission on State Hospital Problems in its report of a study recently submitted to the governor of the state.

The report states that the insulin-treated patients did substantially better than the non-treated patients as to comparable length of hospital stay, ability to leave the hospital and resume normal living, numbers at home after varying periods in the hospital, and the extent to which they are restored to usefulness.

A total of 2,004 dementia praecox patients was studied. Of these, 1,128 patients received insulin shock therapy at Brooklyn State Hospital from January 1, 1937 to June 30, 1942, and 876, who received no shock therapy and who were admitted during the same period to other state hospitals, were used as a control group for purposes of comparison.

Of the 1,128 insulin-treated patients, 79.5 were able to leave the hospital as against 58.8 percent of the 876 non-treated patients. The treated group stayed in the hospital 3.2 months, the non-treated group 7 months. At the time of the study, 58.9 percent of those who had received the shock treatment were at home compared with 44 percent not so treated. More than half or 55 percent of the insulin treated patients were functioning as useful members of the community in contrast to 40.5 percent of the non-treated patients. Many were earning their living or more, and some were getting along better than before they became ill.

Neuropsychiatric Case Study—An extensive study of 623 men rejected for or discharged from the armed forces for neuropsychiatric reasons reveals that about 80 percent of the group were found to need some form of psychiatric help although only about 5 percent were getting it. The study was planned to determine the kinds and extent of care and help needed for rehabilitation of the men, and the facilities available to meet such needs. It shows that the majority of the men are neither aware of their need of psychiatric help nor recognize its value. Of 492 men needing such help, only 25 percent understood the need. In a report on the study, the New York City Committee on Mental Hygiene of the State Charities Aid Association stated that much greater community facilities are needed to meet the needs of the men and that there must be prompt and maximum coordination of effort by every available resource in the community, and new plans by both voluntary and public agencies, on a scale not yet contemplated by anyone. The lack of facilities needed is reflected in the fact that of 123 men who knew that they needed psychiatric help and wished to have it, only slightly more than one in six were actually receiving it.

Of 314 *rejected* men studied, 257 needed psychiatric help; 151, organic medical and surgical treatment; 139, vocational counsel and aid; 46, neurological; 24, family case work; 15, group or recreational, and 15, educational. Some men required more than one kind of treatment or help. The comparable figures for the *discharged* groups are similar.

The need for greater psychiatric facilities, the report states, is in sharp contrast to the situation with respect to available resources for the common types of medical and surgical treatments. Of those who want help (close to 75 percent for both groups) between 80 and 90 percent are receiving the medical and surgical aid they require as against only 17.5 percent of the neuropsychiatric cases who are getting the treatment they need.

The report stated that many rejectees and veterans suffering from clear-cut neuroses are spending substantial sums of money on "useless, repeated, common medical procedures and investigations. As long as there are inadequate facilities for psychiatric therapy, and as long as there is inadequate effort made to inform these men of the nature of their needs, this situation will continue."

National Consideration of V D Control—The necessity for both local and national cooperation in venereal disease control, and ways to maintain during the demobilization period the progress made during the war were discussed at the first meeting of the National Venereal Disease Committee in Washington recently. The committee of 15 was appointed by Paul V. McNutt, Federal Security Administrator, "to plan new programs in the fight against venereal diseases and their spread." It is composed of representatives of private organizations, the Army and Navy, USPHS, and the Social Protection Division of the Federal Security Agency.

Mr. McNutt, in announcing results of the meeting, said efforts of the committee represent a further step in the VD control program carried on jointly with the Army, Navy and FSA. This program has resulted in reducing Army and Navy VD rates to their lowest point in history despite a slight current increase. Factors entering into the rise of VD cases as reported by the armed services include increased reporting of infections with the advent of penicillin and the short period required for treatment; a war-caused shortage of trained VD men in this country; and the possibility of laxity induced by over-reliance on new methods of treatment.

USPHS physicians have reported a new and serious factor in venereal disease control in that penicillin used to treat gonorrhea may mask or hide symptoms of syphilis in patients who have both diseases. The importance of avoiding this occurrence is urged, by making special microscopic tests for syphilis before penicillin is used, and by performing blood tests after penicillin treatment is completed. The relatively small amounts of penicillin required to cure gonorrhea are sufficient to cause disappearance of the spirochete germs from syphilis sores, although not sufficient actually to cure the disease. A blood test for syphilis some time after treatment of gonorrhea has been completed is advisable.

International and postwar venereal disease control, and other specialized subjects will be discussed at the Third National Venereal Disease Control Conference conducted under the auspices of the USPHS at St. Louis, Missouri, November 9-11.

Treatment of Burns Reviewed—In a review of the present status of the treatment of burns (*The Journal of the AMA*, August 5, 1944) by the Councils on Industrial Health and Pharmacy and Chemistry of the AMA it is hoped to show that "the ideal agent has not been developed, that highly complex mixtures are as irrational for this form of treatment as for others, that each new highly publicized treatment or drug should be studied with a critical eye before accepting the accompanying claims, that the best treatment on the whole is the simplest and that any treatment is a tedious and painstaking undertaking."

Widely varying local measures for the treatment of burns have been reported in the last decade, states the Council's report, and examination of these methods supports the belief that there is no single preparation which will meet the needs of all cases of burns. The medicinal preparations more commonly employed at this time and their respective uses and merits are discussed: tannic acid, aniline dyes, sulfadiazine spray, saline baths, oiled silk (Bunyan) envelop, pressure dressings, growth stimulating preparations, the sulfonamides, and other miscellaneous agents.

First aid treatment of burns is summarized in the report as follows:

"If only reddening of the skin has resulted from the burn and the superficial (first degree) nature of the lesion can be definitely ascertained, the application of a soothing ointment may be allowed. When blistering or tissue destruction have occurred and hospital facilities are close at hand, most authorities are agreed that no local medication other than a covering of sterile dressings should be applied, or, lacking that, a clean cloth of any nature.

"If the burn is extensive (which some have estimated as 20 percent of the body surface), anti-shock treatment is imperative and should include the administration of morphine and an avoidance of everything which might cause fluid or plasma loss or exudation. If hospital admission is delayed, the first intravenous plasma (solution of crystalloid substances such as dextrose or sodium chloride may be actually harmful) should be begun if at all practical; 500 cc. may be given without waiting for blood studies. Greasy applications are avoided by many on the grounds that they produce only moderate alleviation of pain (a function better performed by morphine) and add to the difficulties of properly cleansing the burned area. . . . On receiving an emergency call the physician may advantageously warn his informant or the victim's helpful neighbors to put nothing on the wound before his arrival . . .

"If the patient cannot be transferred to a hospital for several hours (12 to 24) some form of local dressing may be necessary. Such dressings should aim at preventing external loss of fluid, relieving pain and preventing further contamination. . . . Shock treatment is even more imperative under these conditions than if a hospital is readily available."

Two basic principles emerge in the review—(1) that, "properly applied, many of the more established local measures may give good results if the systemic care of the patient is adequate and (2) that gentle cleansing and no unnecessary debridement of the burned area is essential for the successful application of any of the local methods of burn therapy." Also apparent is the pronounced change in medical opinion regarding the use of tannic acid and other tannic agents (PUBLIC HEALTH NURSING, September 1943, p. 538).

In conclusion the report states that "no method which has been presented to date makes the proper care of burns anything but a tedious and time consuming procedure, the results of

(Continued on page A8)

News

(Continued from page 601)

which are frequently disappointing. The alternatives are clear: high mortality and morbidity, loss of function and disfiguration for the patient. . . . All burns should be regarded as potentially serious wounds."

Interstate Migration and Postwar Outlook—Guesses as to how figures on interstate migrations will shift after the war are being made. While some migrants are now citizens of the states to which they have moved, earning a living is of primary importance if they are to remain after war production ceases. The need for planning—federal, state and local—is evident. The U. S. Census Bureau bulletin, "Interstate Migration and Other Population Changes: 1940 to 1943" (Series P-44, No. 17, August 28, 1944) states that of the eight geographical areas, four —New England, East North Central, South Atlantic, and Pacific—showed net gains through civilian migration. California is the only state that gained more than 1,000,000. Michigan is second with 281,000. Oklahoma showed the greatest loss, 304,000. The "Map Showing Changes in Civilian Population of the United States, by Counties: April 1, 1940 to November 1, 1943" appears in another Bureau bulletin (Series P-44, No. 4, March 23, 1944). A glance shows that counties having increases lie for the most part along the coast lines, and along the Great Lakes, and that those with decreases lie in states between the Mississippi and Rocky Mountains. Yet almost every state has one section with heavy increases caused by the location of an army camp or war industry.

Importance of Dishwashing in Restaurants—The dirty-dish menace in relation to its spread of disease, pronounced because of wartime shortages of help, is receiving increased attention. Surgeon General Thomas Parran has reported (*Public Health Reports,* August 20, 1943, p. 1281) that much of the 60 percent increase in dysentery could be blamed on food handlers, and the USPHS has recently conducted swab tests of restaurant utensils in numerous sections of the community and advised U. S. cities to provide courses in dishwashing methods. Because of evidence that the amount of disease spread in restaurants is increasing, health departments are advised in the *Journal* of the AMA, September 30, 1944, to intensify their efforts at control. *Health Officers News Digest* for September reports on results to date of food-handlers' schools conducted throughout the country. A total attendance of well over 15,000 in recent weeks "bodes well for the health of the nation's 'diners-out,'" states the *Digest*.